| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055189 | A. Building<br>B. Wing | 03/13/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Greenfield Care Center of Fairfield | 1260 Travis Blvd<br>Fairfield, CA 94533 |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Reasonably accommodate the needs and preferences of each resident.<br><br>47197<br><br>Based on observation, interview, and record review, the facility failed to provide reasonable accommodation of resident needs for two of 31 sampled residents (Resident 16 and Resident 266) when:<br><br>1. Resident 16's call light system was not appropriate; and,<br><br>2. Resident 266's call light system was broken, and she was provided with a nonfunctional alternative.<br><br>This failure placed Resident 16 and Resident 266's safety at risk and had the potential for the residents' needs to be not met.<br><br>Findings:<br><br>1.A review of Resident 16's clinical record indicated Resident 16 was admitted January of 2025 and had diagnoses that included osteomyelitis (inflammation of bone or bone marrow, usually due to infection), need for assistance with personal care, muscle weakness, epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures, and lack of expected normal physiological [functioning] development in childhood).<br><br>A review of Resident 16's Minimum Data Set (MDS - a federally mandated resident assessment tool) Cognitive Patterns, dated 2/5/25, indicated Resident 16 was rarely or never understood and had severely impaired ability on making decisions regarding tasks of daily living. A review of Resident 16's MDS Functional Abilities, dated 2/5/25, indicated Resident 16 was dependent with eating, oral hygiene, toileting, shower/bathing self, upper and lower body dressing, and personal hygiene. Resident 16's MDS Functional Abilities further indicated Resident 16 had impairment on both arms and both legs.<br><br>During an observation on 3/10/25 at 9:27 a.m. in Resident 16's room, Resident 16 was observed lying on bed, awake, and had a call light button on the side of his bed. Resident 16 was asked to press the call light button but was not able to press the button.<br><br>During a concurrent observation and interview on 3/10/25 at 11:45 a.m. with Certified Nurse Assistant (CNA) 3, in Resident 16's room, CNA 3 confirmed Resident 20 was given a call light button to use whenever he needs help. CNA 3 stated Resident 16 was not able to use and push the call light button. CNA 3 further stated Resident 16 needs total care and is totally dependent to staff.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 3/11/25 at 3:45 p.m. with Restorative Nurse Assistant (RNA) 1, RNA 1 stated Resident 16 was not able to use and push the call light button. RNA 3 also stated Resident 16 was able to move his hands but not his fingers. RNA 3 further stated Resident 16 responds on simple commands and would benefit when using an alternative means of the call system like a soft touch pad (call system which is activated with a very light touch).<br><br>During a concurrent observation and interview on 3/11/25 at 3:53 a.m. with Licensed Nurse (LN) 7, in Resident 16's room, LN 7 confirmed Resident 16 was given a call light button to use. LN 7 stated Resident 20 was not able to use the call light button. LN 7 also stated Resident 20 needed the soft touch pad instead of the call light button that he was provided with.<br><br>2. A review of Resident 266's clinical record indicated Resident 266 was admitted March of 2025 and had diagnoses that included respiratory failure (is a serious condition that develops when the lungs can't get enough oxygen into the blood and makes it difficult for a person to breathe on his/her own), major depressive disorder (persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), heart failure (a serious condition in which the heart does not pump blood as efficiently as it should), and chronic (long-term) pain.<br><br>A review of Resident 266's admission History and Physical, dated 3/6/25, indicated Resident 266 was oriented to person, place and time, and Has the capacity to understand and make medical decisions. Further review of the document indicated Resident 266 has been essentially bedbound [confined to bed, unable to move around safely or comfortably, and often due to illness, injury, or weakness] and was at high risk for falls and activities of daily living decline.<br><br>During a concurrent observation and interview on 3/10/25 at 9:27 a.m. with Resident 266, in Resident 266's room, Resident 266 was asked where her call light was and she pointed at the blue string connected to the wall, where the call light plug was, going to her bed and was tied on the right bedside rail. Resident 266 stated when she was moved to her room, she was told that the call light was broken and then she was given the blue string to pull when she needed help. Resident 266 then tried to pull the blue string but was not able to because the string was tangled with the bed wires.<br><br>A review of Resident 266's clinical records indicated Resident 266 was moved to her room on 3/6/29.<br><br>During a concurrent observation and interview on 3/10/25 at 10:29 a.m. with the Social Services Director (SSD), in Resident 266's room, the SSD confirmed that Resident 266's call light was broken and was given a blue string to pull as an alternative call light system. The SSD also confirmed that the blue string was tangled with the bed wires so Resident 266 was not able to use it. The SSD stated the blue string was not a functional call light system.<br><br>A review of the facility's MAINTENANCE LOG, dated 3/9/25, indicated, [Resident 266's room and bed letter], CALL LIGHT BROKEN, SINCE TRANSFERRED FROM [Resident 266's old room and bed letter] to [Resident 266's room and bed letter] .RESULT .DONE .<br><br>During an interview on 3/12/25 at 10:23 a.m. with Maintenance Assistant (MA) 1, MA 1 confirmed Resident 266's call light was broken, and he gave her a blue string to use as an alternative call light system for the mean time. MA 1 stated they were still in process of fixing Resident 266's call light. MA 1 further stated she would expect staff to place the report [of a broken call light] right away in the maintenance log so they would be alerted about it right away.<br><br>(continued on next page) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 3/13/25 at 9:41 a.m. with the Director of Nursing (DON), the DON stated if a resident was not able to press the call light button, an alternative call system, like soft touch pad, would be provided. The DON also stated she would expect residents to be provided with a functional call system. The DON further stated there would be a risk for residents' needs to be not met and pose a safety risk if residents' call systems were not appropriate or not functional.<br><br>A review of the facility's policies and procedures (P&P) titled, CALL LIGHT/BELL, revised 1/2025, indicated, It is the policy of this facility to provide the resident a means of communication with nursing staff .6. If call light is defective, promptly report this information to the unit supervisor for immediate repair or replacement.<br><br>A review of the facility's policies and procedures (P&P) titled, Accommodation of Needs, revised 1/2025, indicated, Our facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving safe independent functioning, dignity, and well being .1. The resident's individual needs and preferences are accommodated to the extent possible. |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some | Provide appropriate treatment and care according to orders, resident’s preferences and goals.<br><br>47197<br><br>Based on observation, interview, and record review, the facility failed to ensure residents received treatment and care to attain and maintain their highest practical wellbeing consistent with professional standards of practice and facility's policy and procedure (P&P) for nine out of 31 sampled residents (Resident 265, 60, 267, 264, 266, 160, 262, 263, and 48) when:<br><br>1. Resident 265's prescribed pain medication, and Resident 60 and Resident 267's prescribed medications were ordered late;<br><br>2. Resident 264's order for pain medication was sent to the pharmacy without a valid prescription order and another prescribed medication was ordered late;<br><br>3. Resident 266's order for pain medications were sent to the pharmacy without valid prescription orders and another prescribed medication was returned to the facility for a signature and additional authorization, which caused the delay;<br><br>4. Resident 160's order for pain medications and two other medications were authorized late;<br><br>5. Resident 262 and Resident 263 did not receive their prescribed medication in a timely manner in accordance with the physician's order; and,<br><br>6. When Licensed Nurse (LN) 2 did not safely administer medications via the gastrostomy tube (G Tube -a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) for Resident 48 as per physician's orders and professional standards.<br><br>These failures resulted in Resident 265, 60, 267, 264, 266, 160, 262, and 263 not receiving their medications on time which subsequently resulted in Resident 265, 264, 266, and 160 experiencing unnecessary pain and emotional distress that had negatively affected the residents' level of comfort, activity and sleep, and risk for Resident 48 to have an unsafe medication administration.<br><br>Findings:<br><br>1a. A review of Resident 265's clinical record indicated Resident 265 was admitted February of 2025 and had diagnoses that included fracture (a break in the continuity of a bone) of left humerus (upper arm bone), neuralgia (pain caused by irritation or damage to a nerve) and neuritis (inflammation of a nerve), and need for assistance with personal care.<br><br>A review of Resident 265's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns (mental process of acquiring knowledge and understanding)., dated 3/2/25, indicated Resident 265 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 10 out of 15 which indicated Resident 265 had a moderately impaired cognition. A review of Resident 265's MDS Health Conditions, dated 3/2/25, indicated Resident 265 had frequently experienced pain or hurting which frequently made it hard for her to sleep at night, occasionally limited her participation in rehabilitation therapy sessions, and occasionally limited her day-to-day activities.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some | A review of Resident 265's progress notes, dated 2/19/25, indicated Resident 265 arrived at the facility on 2/19/25 at around 11:58 p.m. and has a pain level of 4/10 (numeric pain scale from 1 to 10; 1-3 is mild pain, 4-7 is moderate pain, 8-10 is severe pain).<br><br>A review of Resident 265's physician's order, dated 2/19/25 at 12:13 p.m., indicated, MS Contin (Morphine Sulfate) [a strong medication used to treat moderate to severe pain] Oral Tablet Extended Release 30 MG [milligrams- unit of measurement] Give 1 tablet by mouth every 8 hours for Pain management.<br><br>A review of Resident 265's care plan, initiated 2/19/25, indicated, At risk for pain or discomfort related to left humeral fracture due to ground fall at home. A review of Resident 265's care plan intervention, initiated 2/19/25, indicated, Administer pain meds as MD (Medical Doctor) ordered .MS Contin Oral Tablet .for Pain management.<br><br>A review of Resident 265's Medication Administration Record (MAR- a legal document used to record medications given to the residents), for the month of February 2025, indicated Resident 265's morphine sulfate was scheduled to be administered every 8 a.m., 4 p.m., and 12 midnight, with the first dose scheduled on 2/19/25 at 4 p.m. A further review of the MAR indicated the 4 p.m. of the morphine sulfate on 2/19/25 was marked with a chart code 5, which indicated the medication was held and not given to the resident.<br><br>A review of Resident 265's Weights and Vitals Summary, dated 2/19/25 at 8:38 p.m., indicated Resident 265 had a pain level of 8 [severe pain].<br><br>During an interview on 3/10/25 at 9:42 a.m. with Resident 265, Resident 265 stated she did not receive her morphine medication on the day she was admitted in the facility. Resident 265 also stated her pain was so awful that day, it went to a level of 9 out of 10 (severe pain). Resident 265 further stated, Well, It [sleeping] was hard .I got hard time sleeping .I was in so much pain.<br><br>During a concurrent interview and record review on 3/11/25 at 4:22 p.m. with LN 6, Resident 265's MAR for February 2025 was reviewed. LN 6 confirmed that Resident 265's morphine sulfate was not given on 2/19/25 at 4 p.m. LN 6 stated there was a risk for Resident 265 to be in so much pain when the morphine sulfate was not given.<br><br>During a concurrent phone interview and record review on 3/13/25 at 10:54 a.m. with the Pharmacist from the Facility's Pharmacy (PP), Resident 265's medication orders were reviewed. The PP stated they only received Resident 265's medication order for morphine sulfate on 2/19/25 at 7:41 p.m. and had filled and sent it on the next scheduled delivery time which was 10:30 pm.<br><br>During a concurrent interview and record review on 3/13/25 at 11:46 a.m. with the Admissions Coordinator (AC), Resident 265's medication records were reviewed. The AC showed a fax receipt indicating Resident 265's prescription order of morphine sulfate was sent to their pharmacy on 2/19/25 at 5:53 p.m. The AC confirmed the prescription order was faxed after the scheduled administration. The AC stated that sometimes it would take 4 hours for nurses to transcribe medication orders which causes the delay in faxing medication orders.<br><br>A review of the Shipping Manifest [receipt] for Resident 265's morphine sulfate indicated the facility received the medication on 2/19/25 at 10:35 p.m.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some | 1b. A review of Resident 60's clinical record indicated Resident 60 was admitted March of 2025 and had diagnoses that included thrombocytosis (a condition characterized by an abnormally high number of clotting components in the blood) and benign prostatic hyperplasia (BPH- the prostate gland grows larger than normal potentially causing urinary problems).<br><br>A review of Resident 60's admission History and Physical, dated 3/5/25, indicated Resident 60 was oriented to person, place and time, but Does not have the capacity to understand and make medical decisions.<br><br>A review of Resident 60's progress notes, dated 3/5/25, indicated Resident 60 arrived at the facility on 3/4/25 at 3:05 p.m.<br><br>A review of Resident 60's physician's order, dated 3/4/25 at 4:40 p.m., indicated, Tamsulosin HCL(Hydrochloride) [a medication used to treat enlarged prostate] Oral Capsule 0.4 MG . Give 1 capsule by mouth at bedtime related to BENIGN PROSTATIC HYPERPLASIA .<br><br>A review of Resident 60's physician's order, dated 3/4/25 at 4:43 p.m., indicated, Apixaban [a medication used to treat and prevent blood clots and to prevent stroke] Oral Tablet 2.5 MG . Give 1 tablet by mouth two times a day .<br><br>A review of Resident 60's MAR for the month of March 2025, indicated Resident 60's tamsulosin was scheduled to be administered starting 3/4/25 every 9 p.m. and the apixaban was scheduled every 9 a.m. and 9 p.m., with first dose on 3/4/25 at 9 p.m. A further review of the MAR indicated the 9 p.m. doses for tamsulosin and apixaban on 3/4/25 were marked with a chart code, 5, which indicated the medications were held and not given to the resident.<br><br>A review of Resident 60's progress notes, dated 3/5/25 at 6:56 a.m., indicated, .f/u [follow up] with pharmacy as medication not delivered.as per pharmacy they did not receive the face sheet and order. Refaxed all the order and face sheet. Requested stat [immediate] delivery of medication. endorsed to next shift .<br><br>During an interview on 3/11/25 at 4:08 p.m. with Resident 60, Resident 60 stated he could not remember if he got all his medications when he was admitted in the facility.<br><br>During a concurrent interview and record review on 3/11/25 at 4:22 p.m. with LN 6, Resident 60's MAR was reviewed. LN 6 confirmed that 9 p.m. doses of Resident 60's tamsulosin and apixaban on 3/4/25 were not given. LN 6 stated there was a risk for Resident 60 to develop impaired circulation when the apixaban was not given and a risk to negatively affect Resident 60's health when the tamsulosin was not given.<br><br>During a concurrent phone interview and record review on 3/12/25 at 11:51 a.m. with the Pharmacy Technician (PPT) from the Facility's Pharmacy, Resident 60's medication orders were reviewed. PPT stated they only received Resident 60's medication orders for tamsulosin and apixaban on 3/5/25 at 4:18 a.m. and had filled and sent it on the next scheduled delivery time.<br><br>A review of the Shipping Manifest for Resident 60's tamsulosin and apixaban indicated the facility received the medication on 3/5/25 at 10:30 a.m.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some | 1c. A review of Resident 267's clinical record indicated Resident 267 was admitted March of 2025 and had diagnoses that included asthma (a condition in which a person's airways become inflamed, narrow, and swell, and produce extra mucus, which makes it difficult to breathe) and gastro-esophageal reflux disease (GERD- a condition where stomach acid flows back up into the esophagus causing symptoms like heartburn and regurgitation).<br><br>A review of Resident 267's admission History and Physical, dated 3/5/25, indicated Resident 60 was oriented to person, place and time, and Has the capacity to understand and make medical decisions.<br><br>A review of Resident 267's progress notes, dated 3/4/25, indicated Resident 267 arrived at the facility at around at 3 p.m.<br><br>A review of Resident 267's physician's order, dated 3/4/25 at 4:40 p.m., indicated, Fluticasone-Salmeterol Inhalation [a combination medication used to treat asthma] .500-50 MCG/ACT [unit of measurement] .1 puff inhale orally one time a day for asthma .<br><br>A review of Resident 267's physician's order, dated 3/4/25 at 6:29 p.m., indicated, Pantoprazole Sodium [a medication used to treat GERD] Oral Capsule 100 MG . Give 1 capsule by mouth two times a day for GERD .<br><br>A review of Resident 267's MAR for the month of March 2025, indicated Resident 267's fluticasone-salmeterol inhalation was scheduled to be administered starting 3/5/25 every 9 a.m. and the pantoprazole was scheduled every 6:30 a.m. and 4:30 p.m., with first dose on 3/5/25 at 6:30 a.m. A further review of the MAR indicated the 9 a.m. dose of fluticasone-salmeterol inhalation and 6:30 a.m. dose of pantoprazole for Resident 267 on 3/5/25 were marked with a chart code, 5, which indicated the medications were held and not given to the resident.<br><br>A review of Resident 267's progress notes, dated 3/5/25 at 4:19 p.m., indicated, Fluticasone spray unable to give, waiting for pharmacy delivery .<br><br>During an interview on 3/10/25 at 11:10 a.m. with Resident 267, Resident 267 stated she did not receive some of her medications when she was admitted in the facility. Resident 267 also stated it was upsetting for her to wait that long for her medications.<br><br>During a concurrent interview and record review on 3/11/25 at 4:22 p.m. with LN 6, Resident 267's MAR was reviewed. LN 6 confirmed the 9 a.m. dose of fluticasone-salmeterol inhalation and 6:30 a.m. dose of pantoprazole for Resident 267 on 3/5/25 were not given. LN 6 stated there was a risk for Resident 267 to develop gastric acidity when the pantoprazole was not given and a risk to develop difficulty breathing when the fluticasone-salmeterol inhalation was not given.<br><br>During a concurrent phone interview and record review on 3/12/25 at 11:51 a.m. with the PPT, Resident 60's medication orders were reviewed. PPT stated they only received Resident 267's medication orders for fluticasone-salmeterol inhalation and pantoprazole on 3/5/25 at 12:35 p.m. and had filled and sent it on the next scheduled delivery time.<br><br>A review of the Shipping Manifest for Resident 267's fluticasone-salmeterol inhalation and pantoprazole indicated the medications were received by the facility on 3/5/25 at 3:20 p.m.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some | 2. A review of Resident 264's clinical record indicated Resident 264 was admitted February of 2025 and had diagnoses that included osteoarthritis (OA- a deteriorating disease that causes pain, stiffness, and swelling where two or more bones meet), pain in right hip, diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), neuropathy (a nerve condition that can cause pain, numbness, tingling, or weakness in the body), chronic pain syndrome (condition that involves persistent pain that lasts for weeks to years), and major depressive disorder (persistently depressed mood or loss of interest in activities, causing significant impairment in daily life).<br><br>A review of Resident 264's MDS Cognitive Patterns, dated 2/26/25, indicated Resident 264 had a BIMS score of 15 out of 15 which indicated Resident 264 had an intact cognition. A review of Resident 264's MDS Health Conditions, dated 2/26/25, indicated Resident 264 had frequently experienced pain or hurting which frequently made it hard for her to sleep at night, frequently limited her participation in rehabilitation therapy sessions, and frequently limited her day-to-day activities.<br><br>A review of Resident 264's physician's order, dated 2/19/25 at 3:06 p.m., indicated, Pregabalin [a drug used to treat nerve and muscle pain] Oral Capsule 150 MG . Give 1 capsule by mouth two times a day related to PAIN IN RIGHT HIP .<br><br>A review of Resident 264's MAR, for the month of February 2025, indicated Resident 264's pregabalin was scheduled to be administered every 9 a.m. and 5 p.m., with the first dose on 2/19/25 at 5 p.m. A further review of the MAR indicated that Resident 264's dose of pregabalin on 2/19/25 at 5 p.m., 2/20/25 at 9 a.m. and 5 p.m., and 2/21/25 at 9 a.m. were all marked with a chart code 5, which indicated the medication was held and not given to the resident.<br><br>A review of Resident 264's physician's order, dated 2/20/25 at 7:48 p.m., indicated, metFORMIN HCl [a medication used to treat high blood sugar levels] Oral Tablet 500 MG . Give 1 tablet by mouth two times a day for DM.<br><br>A review of Resident 264's MAR, for the month of February 2025, indicated Resident 264's metformin was scheduled to be administered starting 2/21/25 every 9 a.m. and 5 p.m. A further review of the MAR indicated the metformin 9 a.m. dose on 2/21/25 was marked with a chart code, 5, which indicated the medication was held and not given to the resident.<br><br>A review of Resident 264's care plan, initiated 2/19/25, indicated, At risk for alteration in comfort/pain related to recent fall with right hip pain, chronic back pain .DM . A review of Resident 264's care plan intervention, initiated 2/19/25, indicated, Administer pain meds as MD ordered .<br><br>A review of Resident 264's progress notes, dated 2/20/25 at 2:19 p.m., indicated, Followed up with [name of facility pharmacy] about Pregabalin; no response from doctor for authorization. Additional message was left for doctor by pharmacy staff.<br><br>During an interview on 3/10/25 at 9:48 a.m. with Resident 264, Resident 264 stated she did not get all her medications on the first few days when she was admitted in the facility, including her pain medication. Resident 264 also stated her pain level was so bad which she rated at 10 (severe pain). Resident 265 further stated, I was hurting .I cannot move or do anything .so I just stayed here in the room on those days .I was just in bed because I can't do anything .I was not comfortable, I was in a lot of pain .I was so upset to wait that long for it [pain medication] .<br><br>(continued on next page) |

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|---|---|
| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some | During a concurrent interview and record review on 3/11/25 at 4:22 p.m. with LN 6, Resident 264's MAR for February 2025 was reviewed. LN 6 confirmed that Resident 264's pregabalin was held and not given on 2/19/25 at 5 p.m., 2/20/25 at 9 a.m. and 5 p.m., and 2/21/25 at 9 a.m. LN 6 stated there was a risk for Resident 264 to have her pain not relieved when the pregabalin was not given for four times. LN 6 also confirmed that Resident 264's metformin was held and not given on 2/21/25 at 9 a.m. LN 6 further stated there was a risk for Resident 264 to have high blood sugar when the metformin was not given.<br><br>During a concurrent phone interview and record review on 3/12/25 at 11:51 a.m. with PPT, Resident 264's medication orders were reviewed. PPT stated they only received Resident 264's valid prescription order for pregabalin from the doctor on 2/21/25 at 7:32 a.m. and had filled and sent it on the next scheduled delivery time. PPT also stated they only received Resident 264's medication order for metformin on 2/21/25 at 8:06 a. m. and had filled and sent it on the next scheduled delivery time.<br><br>During a concurrent interview and record review on 3/13/25 at 11:46 a.m. with the AC, Resident 264's medication records were reviewed. The AC stated Resident 264 came from a local hospital that sends medication order to their pharmacy electronically in which they're having problems with. The AC also stated that their nurse would then need to call their facility doctor to get the actual prescription order and fax it the pharmacy. The AC then confirmed that there was no valid prescription order for Resident 264's pregabalin that was faxed to the pharmacy.<br><br>A review of the Shipping Manifest for Resident 264's pregabalin and metformin indicated the facility received the medication on 2/21/25 at 1:45 p.m.<br><br>3. A review of Resident 266's clinical record indicated Resident 266 was admitted March of 2025 and had diagnoses that included neuralgia and neuritis, osteoarthritis, chronic pain, respiratory failure (is a serious condition that develops when the lungs can't get enough oxygen into the blood and makes it difficult for a person to breathe on his/her own) and chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing).<br><br>A review of Resident 266's admission History and Physical, dated 3/6/25, indicated Resident 266 was oriented to person, place and time, Has the capacity to understand and make medical decisions, and was a high risk for fall and Activities of Daily Living (ADL- normal daily functions required to meet basic needs) decline.<br><br>A review of Resident 266's progress notes, dated 3/4/25, indicated Resident 266 arrived at the facility at around 11:30 a.m.<br><br>A review of Resident 266's physician's order, dated 3/4/25 at 2:33 p.m., indicated, Buprenorphine [a strong medication used to treat moderate to severe pain] HCl Sublingual [below the tongue] Tablet Sublingual 8 MG . Give 1 tablet sublingually two times a day for Chronic pain.<br><br>A review of Resident 266's physician's order, dated 3/4/25 at 2:33 p.m., indicated, Pregabalin Oral Capsule 25 MG . Give 1 capsule by mouth two times a day related to NEURALGIA AN NEURITIS .<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 055189 | A. Building<br>B. Wing | 03/13/2025 |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some | A review of Resident 266's physician's order, dated 3/4/25 at 2:33 p.m., indicated, Dulera [a prescription medicine used to control symptoms such as difficulty breathing] Inhalation Aerosol 200-5 MCG/ACT [micrograms/puff] .2 puff inhale orally two times a day related to CHRONIC OBSTRUCTIVE PULMONARY DISEASE .<br><br>A review of Resident 266's MAR for the month of March 2025, indicated Resident 266's buprenorphine, pregabalin, and dulera inhalation were scheduled to be administered every 9 a.m. and 5 p.m., with first dose on 3/4/25 at 5 p.m. A further review of the MAR indicated the 5 p.m. dose of buprenorphine on 3/4/25, the pregabalin 5 p.m. dose on 3/4/25 and 9 a.m. dose on 3/5/25, and the dulera inhalation 5 p.m. dose on 3/4/25 and 9 a.m. dose on 3/5/25 were all marked with chart code, 5, which indicated the medications were held and not given to the resident.<br><br>A review of Resident 266's care plan, initiated 3/4/25, indicated, At risk for pain or discomfort related to: .> NEURALGIA AND NEURITIS .> OA. >Chronic Pain. A review of Resident 266's care plan intervention, initiated 3/4/25, indicated, Administer pain meds as MD ordered .Buprenorphine HCl .Pregabalin Oral Capsule .<br><br>A review of Resident 266's progress notes, dated 3/5/25 at 12:58 a.m., indicated, .some of the medication still to be delivered from pharmacy .<br><br>A review of Resident 266's Weights and Vitals Summary, indicated Resident 266 had pain levels as follows:<br><br>3/5/25 at 12:39 a.m.- 5 (moderate pain),<br><br>3/5/25 at 9:40 a.m.- 5 (moderate pain),<br><br>3/5/25 at 4:40 a.m.- 7 (moderate pain).<br><br>During an interview on 3/10/25 at 10:04 a.m. with Resident 266, Resident 266 stated she did not get all her medications when she was admitted , including her pain medications. Resident 266 also stated she had pain on the days she did not receive her pain medications which she rated at a level of 9 out of 10 (severe pain). Resident 266 further stated, I was in so much pain .I tried to rest but I could not sleep at all that night .It's [pain] so bad.<br><br>During a concurrent interview and record review on 3/11/25 at 4:22 p.m. with LN 6, Resident 266's MAR was reviewed. LN 6 confirmed that Resident 266's 5 p.m. dose of buprenorphine on 3/4/25, the pregabalin 5 p.m. dose on 3/4/25 and 9 a.m. dose on 3/5/25, and the dulera inhalation dose on 3/4/25 at 5 p.m. and on 3/5/25 at 9 a.m. were not given. LN 6 stated there was a risk for Resident 266 to have uncontrolled pain when the buprenorphine and pregabalin was not administered and there a risk to develop difficulty breathing when the dulera inhalation was not given.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some | During a concurrent phone interview and record review on 3/13/25 at 8:58 a.m. with the PPT, Resident 266's medication orders were reviewed. PPT stated they received Resident 266's medication order for buprenorphine from the facility on 3/4/25 at 3:27 p.m., they had to send the order to the doctor for approval and only received the valid prescription order for buprenorphine on 3/4/25 at 5:55 p.m. then they had filled and sent it on the next scheduled delivery time. PPT also stated they received Resident 266's medication order for dulera inhalation on 3/4/25 at 3:27 p.m., they needed additional authorization for high-cost medications from the Director of Nursing (DON) which they received on 3/4/25 at 11:36 p.m. and had filled and sent it on the next scheduled delivery time.<br><br>During a concurrent phone interview and record review on 3/13/25 at 10:54 a.m. with the PP, Resident 266's medication orders were reviewed. The PP stated they received Resident 266's medication order for pregabalin on 3/4/25 at 3:27 p.m. but the facility only sent discharge paper, which is not a valid prescription order, so they needed to fax it to the doctor on 3/4/25 at 6:57 p.m. for approval and only received the valid prescription order for pregabalin on 3/5/25 at 10:37 a.m. which then they had filled and sent it on the next scheduled delivery time which was 5:30 pm.<br><br>During a concurrent interview and record review on 3/13/25 at 11:46 a.m. with the AC, Resident 266's medication records were reviewed. The AC then confirmed that there was no valid prescription order for Resident 266's buprenorphine and pregabalin that was faxed to the pharmacy. The AC stated they're aware that controlled medications (medications with high potential for abuse or addiction) like buprenorphine and pregabalin needs valid prescription order before the pharmacy dispense the medication.<br><br>A review of the Shipping Manifest for Resident 266's buprenorphine indicated the facility received the medication on 3/5/25 at 1 a.m.<br><br>A review of the Shipping Manifest for Resident 266's dulera inhalation indicated the facility received the medication on 3/5/25 at 1:20 p.m.<br><br>A review of the Shipping Manifest for Resident 266's pregabalin indicated the facility received the medication on 3/5/25 at 7:10 p.m.<br><br>4. A review of Resident 160's clinical record indicated Resident 160 was admitted March of 2025 and had diagnoses that included migraine (a neurological condition characterized by recurring headaches, often with throbbing pain, sensitivity to light and sound, and sometimes nausea or vomiting), DM with neuropathy, muscle spasm (an involuntary and sudden contraction of a muscle), irritable bowel syndrome (IBS- a gastrointestinal disorder characterized by chronic abdominal pain, bloating, and changes in bowel habits), and anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities).<br><br>A review of Resident 160's admission History and Physical, dated 3/5/25, indicated Resident 160 Has the capacity to understand and make medical decisions and was a high risk for falls and ADL decline.<br><br>A review of Resident 160's physician's order, dated 3/3/25 at 12:46 p.m., indicated, Qulipta [a medication used to prevent episodic and chronic migraine headaches] Oral Tablet 60 MG . Give 1 tablet by mouth one time a day for migraine.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some | A review of Resident 160's physician's order, dated 3/3/25 at 1:27 p.m., indicated, LinaCLOtide [a drug used to treat IBS] Oral Capsule 72 MCG [micrograms- unit of measurement] .Give 1 capsule by mouth one time a day for gastrointestinal agent.<br><br>A review of Resident 160's physician's order, dated 3/3/25 at 2:36 p.m., indicated, Biotin [vitamin B7 supplement] Oral Tablet 10000 MCG .Give 1 tablet by mouth one time a day for supplement.<br><br>A review of Resident 160's MAR for the month of March 2025, indicated Resident 160's Qulipta, linaclotide, and biotin were scheduled to be administered starting 3/4/25 every 9 a.m. A further review of the MAR indicated the qulipta, linaclotide, and biotin 9 a.m. doses on 3/4/25 was marked with a chart code, 5, which indicated the medications were held and not given to the resident.<br><br>A review of Resident 160's care plan, initiated 3/4/25, indicated, At risk for pain or discomfort related to: . >migraine .>muscle spasm .>DM w/ neuropathy. A review of Resident 160's care plan intervention, initiated 3/4/25, indicated, Administer pain meds as MD ordered .Qulipta Oral Tablet .for migraine.<br><br>A review of Resident 160's progress notes, dated 3/4/25 at 2:33 p.m., indicated, .following meds [medications were] not available to be given on time: linaclotide 75mg [sic], Biotin 1000mg, Qulipta 60 mg tabs. Pharmacy contacted and will [be] delivered ASAP [as soon as possible].<br><br>A review of Resident 160's Weights and Vitals Summary, indicated Resident 160 had pain levels as follows:<br><br>3/3/25 at 8:10 p.m.- 8 (severe pain),<br><br>3/3/25 at 10:05 p.m.- 8 (severe pain),<br><br>3/4/25 at 7:38 a.m.- 4 (moderate pain),<br><br>3/4/25 at 8:45 a.m.- 9 (severe pain),<br><br>3/4/25 at 3:47 p.m.- 8 (severe pain),<br><br>3/4/25 at 4:36 p.m.- 6 (moderate pain),<br><br>3/5/25 at 12:25 a.m.- 4 (moderate pain),<br><br>3/5/25 at 12:47 a.m.- 8 (severe pain),<br><br>3/5/25 at 5:22 a.m.- 8 (severe pain).<br><br>During an interview on 3/11/25 at 2:17 p.m. with Resident 160, Resident 160 stated she needed to wait two days to get some of her medications when she was admitted , including her medication for migraines. Resident 160 also stated she had a migraine on those days and was very uncomfortable. Resident 160 further stated, I felt really bad not getting some of it .well, It's upsetting but what can I do .It [missing migraine medication] was not comfortable of course.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some | During a concurrent interview and record review on 3/11/25 at 4:22 p.m. with LN 6, Resident 160's MAR was reviewed. LN 6 confirmed that Resident 160's qulipta, linaclotide, and biotin were not given on 3/4/25 at 9 a. m. LN 6 stated there was a risk for Resident 160 to experience unrelieved migraine or pain when the qulipta was not given. LN 6 also stated there was a risk for Resident 160 to develop constipation when the linaclotide was not given and risk to negatively affect her health when the biotin was not given.<br><br>During a concurrent phone interview and record review on 3/13/25 at 8:58 a.m. with the PPT, Resident 160's medication orders were reviewed. PPT stated they received Resident 160's medication order for qulipta and linaclotide on 3/3/25 at 4:39 p.m., they needed additional authorization for high-cost medications from DON which they received on 3/4/25 at 9:30 p.m. and had filled and sent it on the next scheduled delivery time. PPT also stated the pharmacy did not send the biotin medication to the facility because they needed additional authorization for high-cost medications from the DON.<br><br>A review of the Shipping Manifest for Resident 160's Qulipta indicated the facility received the medication on 3/5/25 at 8:33 a.m.<br><br>A review of the Shipping Manifest for Resident 160's linaclotide indicated the facility received the medication on 3/5/25 at 10:30 a.m.<br><br>5a. A review of Resident 262's clinical record indicated Resident 262 was admitted February of 2025 and had diagnoses that included DM with foot ulcer (open sore or wound) and sepsis (a life-threatening condition that occurs when the body's immune system overreacts to an infection)<br><br>A review of Resident 262's admission History and Physical, dated 3/2/25, indicated Resident 262 Has the capacity to understand and make medical decisions.<br><br>A review of Resident 262's progress notes, dated 2/28/25, indicated Resident 262 arrived at the facility at around 11:35 a.m.<br><br>A review of Resident 262's physician's order, dated 2/26/25 at 3:38 p.m., indicated, Insulin Glargine [a long-acting insulin used to control blood sugar levels] Subcutaneous [under the skin] Solution 100 unit/ML [milliliters- unit of measurement] .Inject 20 unit subcutaneously two times a day for DM.<br><br>A review of Resident 262's MAR for the month of February 2025, indicated Resident 262's insulin glargine was scheduled to be administered every 9 a.m. and 5 p.m., with first dose on 2/28/25 at 5 p.m. A further review of the MAR indicated the insulin glargine 5 p.m. dose on 2/28/25 was marked with a chart code, 5, which indicated the medication was held and not given to the resident.<br><br>A review of Resident 262's progress notes, dated 2/28/25 at 5:34 p.m., indicated, .At 1630pm [4:30 p.m.] BS [Blood sugar was] 149 .Insulin Glargine Subcutaneous Solution 100 UNIT/ML (Insulin Glargine)Inject 20 unit subcutaneously two times a day for DM, not given, per [Nurse Practitioner- an advanced practice registered nurse with advanced clinical training who provides direct patient care, including diagnosing, treating, and managing health conditions, and can prescribe medications] ok to administer when delivered tonight by pharmacy .<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some | During an interview on 3/10/25 at 9:13 a.m. with Resident 262, Resident 262 stated he had to wait for 1-2 days to receive all his medications. Resident 262 further stated, I felt not so good, when asked how he was when he did not receive all his medications.<br><br>During a concurrent interview and record review on 3/11/25 at 4:22 p.m. with LN 6, Resident 262's MAR was reviewed. LN 6 confirmed that Resident 262's Insulin Glargine was held and not given on 2/28/25 at 5 p.m. LN 6 stated there was a risk for Resident 262 to have high blood sugar when the insulin glargine was not given.<br><br>During a concurrent phone interview and record review on 3/12/25 at 11:51 a.m. with the PPT, Resident 262's medication orders were reviewed. PPT stated they received Resident 262's medication order for insulin glargine on 2/28/25 at 2:16 p.m. and had filled and sent it on the next scheduled delivery time.<br><br>A review of the Shipping Manifest for Resident 262's insulin glargine indicated the facility received the medication on 2/28/25 at 8 p.m.<br><br>5b. A review of Resident 263's clinical record indicated Resident 263 was admitted March |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47197<br><br>Based on observation, interview, and record review the facility failed meet the needs of each resident and ensure safe pharmaceutical services for a census of 60 residents when:<br><br>1. Resident 264, 262, 263, 160, 266, 60, 267, 28 and 140 did not received prescribed medications in a timely manner in accordance with the physician's order;<br><br>2. Medication delivery manifest or receipts from provider pharmacy were not signed by two licensed staff for accountability; and,<br><br>3. Facility's policies and procedures (P&P) were not followed for destruction of a controlled medication (medications with high potential for abuse or addiction).<br><br>These failed practices contributed to unsafe and not timely medication use, and had the risk of drug diversion.<br><br>Findings:<br><br>1a. A review of Resident 264's clinical record indicated Resident 264 was admitted February of 2025 and had diagnoses that included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and need for assistance with personal care.<br><br>A review of Resident 264's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns, dated 2/26/25, indicated Resident 264 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 15 out of 15 which indicated Resident 264 had an intact cognition status (mental process of acquiring knowledge and understanding).<br><br>A review of Resident 264's physician's order, dated 2/20/25 at 7:48 p.m., indicated, metFORMIN HCl [a medication used to treat high blood sugar levels] Oral Tablet 500 MG [milligrams- unit of measurement] .Give 1 tablet by mouth two times a day for DM.<br><br>A review of Resident 264's Medication Administration Record (MAR- a legal document used to record medications given to the residents), for the month of February 2025, indicated Resident 264's metformin was scheduled to be administered starting 2/21/25 every 9 a.m. and 5 p.m. A further review of the MAR indicated the metformin 9 a.m. dose on 2/21/25 was marked with a chart code, 5, which indicated the medication was held and not given to the resident.<br><br>During an interview on 3/10/25 at 9:48 a.m. with Resident 264, Resident 264 stated she did not get all her medications on time on the first few days when she was admitted which was disappointing.<br><br>During a concurrent interview and record review on 3/11/25 at 4:22 p.m. with Licensed Nurse (LN) 6, Resident 264's MAR was reviewed. LN 6 confirmed that Resident 264's metformin was held and not given on 2/21/25 at 9 a.m. LN 6 stated there was a risk for Resident 264 to have high blood sugar when the metformin was not given.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a concurrent phone interview and record review on 3/12/25 at 11:51 a.m. with the Pharmacy Technician from the Facility's Pharmacy (PPT), Resident 264's medication orders were reviewed. PPT stated they only received Resident 264's medication order for metformin on 2/21/25 at 8:06 a.m. and had filled and sent it on the next scheduled delivery time.<br><br>A review of the Shipping Manifest (receipt) for Resident 264's metformin indicated the medication was received by the facility on 2/21/25 at 1:45 p.m.<br><br>1b. A review of Resident 262's clinical record indicated Resident 262 was admitted February of 2025 and had diagnoses that included DM with foot ulcer (open sore or wound) and sepsis (a life-threatening condition that occurs when the body's immune system overreacts to an infection)<br><br>A review of Resident 262's admission History and Physical, dated 3/2/25, indicated Resident 262 Has the capacity to understand and make medical decisions.<br><br>A review of Resident 262's progress notes, dated 2/28/25, indicated Resident 262 arrived at the facility at around 11:35 a.m.<br><br>A review of Resident 262's physician's order, dated 2/26/25 at 3:38 p.m., indicated, Insulin Glargine [a long-acting insulin used to control blood sugar levels] Subcutaneous [under the skin] Solution 100 unit/ML [milliliters- unit of measurement] .Inject 20 unit subcutaneously two times a day for DM.<br><br>A review of Resident 262's MAR for the month of February 2025, indicated Resident 262's insulin glargine was scheduled to be administered every 9 a.m. and 5 p.m., with first dose on 2/28/25 at 5 p.m. A further review of the MAR indicated the insulin glargine 5 p.m. dose on 2/28/25 was marked with a chart code, 5, which indicated the medication was held and not given to the resident.<br><br>A review of Resident 262's progress notes, dated 2/28/25 at 5:34 p.m., indicated, .At 1630pm [4:30 p.m.] BS [Blood sugar was] 149 .Insulin Glargine Subcutaneous Solution 100 UNIT/ML (Insulin Glargine)Inject 20 unit subcutaneously two times a day for DM, not given, per [Nurse Practitioner- an advanced practice registered nurse with advanced clinical training who provides direct patient care, including diagnosing, treating, and managing health conditions, and can prescribe medications] ok to administer when delivered tonight by pharmacy .<br><br>During an interview on 3/10/25 at 9:13 a.m. with Resident 262, Resident 262 stated he had to wait for 1-2 days to receive all his medications. Resident 262 further stated, I felt not so good, when asked how he was when he did not receive all his medications.<br><br>During a concurrent interview and record review on 3/11/25 at 4:22 p.m. with LN 6, Resident 262's MAR was reviewed. LN 6 confirmed that Resident 262's Insulin Glargine was held and not given on 2/28/25 at 5 p.m. LN 6 stated there was a risk for Resident 262 to have high blood sugar when the insulin glargine was not given.<br><br>During a concurrent observation and interview on 3/11/25 at 4:55 p.m. with LN 6, the facility's Emergency Kit (Ekit- a supply of medication used for urgent needs of residents) was checked. LN 6 confirmed that insulin glargine is not part of the facility's Ekit supplies.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a concurrent phone interview and record review on 3/12/25 at 11:51 a.m. with the PPT, Resident 262's medication orders were reviewed. PPT stated they received Resident 262's medication order for insulin glargine on 2/28/25 at 2:16 p.m. and had filled and sent it on the next scheduled delivery time.<br><br>A review of the Shipping Manifest for Resident 262's insulin glargine indicated the medication was received by the facility on 2/28/25 at 8 p.m.<br><br>1c. A review of Resident 263's clinical record indicated Resident 263 was admitted March of 2025 and had diagnoses that included DM and cerebral infarction (damage to a part in the brain due to a disrupted blood flow).<br><br>A review of Resident 263's admission History and Physical, dated 3/2/25, indicated Resident 263 was oriented to person and place, and needed assistance to make medical decisions.<br><br>A review of Resident 263's progress notes, dated 3/1/25, indicated Resident 263 arrived at the facility at around 12:30 p.m.<br><br>A review of Resident 263's physician's order, dated 3/1/25 at 12:06 p.m., indicated, Empagliflozin [a medication used to treat DM] Oral Tablet 25 MG . Give 1 tablet by mouth one time a day for lower blood sugar.<br><br>A review of Resident 263's MAR for the month of March 2025, indicated Resident 263's empagliflozin was scheduled to be administered every 5 p.m., which first dose should be on 3/1/25 at 5 p.m. A further review of the MAR indicated the empagliflozin 5 p.m. dose on 3/1/25 was not given to the resident.<br><br>A review of Resident 263's progress notes, dated 3/1/25 at 7:19 p.m., indicated, Called Pharmacy at 18:43 [6:43 p.m.] to follow up all medications, as per [name of pharmacy staff] .it's on its way.<br><br>During an interview on 3/10/25 at 9:28 a.m. with Resident 263, Resident 263 stated he just received his medications the next day when he was admitted . Resident 263 further stated he was not okay with it, but he could not do anything.<br><br>During a concurrent interview and record review on 3/11/25 at 4:22 p.m. with LN 6, Resident 263's MAR was reviewed. LN 6 confirmed that Resident 263's empagliflozin not given on 3/1/25 at 5 p.m. LN 6 stated there was a risk for Resident 263 to have high blood sugar when the empagliflozin was not given.<br><br>During a concurrent phone interview and record review on 3/12/25 at 11:51 a.m. with the PPT, Resident 263's medication orders were reviewed. PPT stated they received Resident 262's medication order for empagliflozin on 3/1/25 at 1:41 p.m. and had filled and sent it on the next scheduled delivery time.<br><br>A review of the Shipping Manifest for Resident 263's empagliflozin indicated the medication was received by the facility on 3/1/25 but did not indicate the time.<br><br>(continued on next page) |

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| | 055189 | A. Building<br>B. Wing | 03/13/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Greenfield Care Center of Fairfield | 1260 Travis Blvd<br>Fairfield, CA 94533 |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 1d. A review of Resident 160's clinical record indicated Resident 160 was admitted March of 2025 and had diagnoses that included DM and irritable bowel syndrome (IBS- a gastrointestinal disorder characterized by chronic abdominal pain, bloating, and changes in bowel habits).<br><br>A review of Resident 160's admission History and Physical, dated 3/5/25, indicated Resident 160 Has the capacity to understand and make medical decisions.<br><br>A review of Resident 160's physician's order, dated 3/3/25 at 2:36 p.m., indicated, Biotin [vitamin B7 supplement] Oral Tablet 10000 MCG [micrograms- unit of measurement] .Give 1 tablet by mouth one time a day for supplement.<br><br>A review of Resident 160's physician's order, dated 3/3/25 at 1:27 p.m., indicated, LinaCLOtide [a drug used to treat IBS] Oral Capsule 72 MCG .Give 1 capsule by mouth one time a day for gastrointestinal agent.<br><br>A review of Resident 160's MAR for the month of March 2025, indicated Resident 160's biotin and linaclotide were scheduled to be administered starting 3/4/25 every 9 a.m. A further review of the MAR indicated the biotin and linaclotide 9 a.m. doses on 3/4/25 was marked with a chart code, 5, which indicated the medications were held and not given to the resident.<br><br>A review of Resident 160's progress notes, dated 3/4/25 at 2:33 p.m., indicated, .following meds [medications were] not available to be given on time: linaclotide 75mg [sic], Biotin 1000mg . Pharmacy contacted and will [be] delivered ASAP.<br><br>During an interview on 3/11/25 at 2:17 p.m. with Resident 160, Resident 160 stated she needed to wait two days to get some of her medications when she was admitted . Resident 160 stated she did not feel comfortable not taking some of her medications.<br><br>During a concurrent interview and record review on 3/11/25 at 4:22 p.m. with LN 6, Resident 160's MAR was reviewed. LN 6 confirmed that Resident 160's biotin and linaclotide were not given on 3/4/25 at 9 a.m. LN 6 stated there was a risk for Resident 160 to develop constipation when the empagliflozin was not given and risk to negatively affect her health when the biotin was not given.<br><br>During a concurrent phone interview and record review on 3/13/25 at 8:58 a.m. with the PPT, Resident 160's medication orders were reviewed. PPT stated the pharmacy did not send the biotin medication to the facility because they needed additional authorization for high-cost medications from the Director of Nursing (DON). PPT further stated they received Resident 160's medication order for linaclotide on 3/3/25 at 4:39 p.m., they needed additional authorization for high-cost medications from DON which they received on 3/4/25 at 9:30 p. m. and had filled and sent it on the next scheduled delivery time.<br><br>A review of the Shipping Manifest for Resident 160's linaclotide indicated the medication was received by the facility on 3/5/25 at 10:30 a.m.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 1e. A review of Resident 266's clinical record indicated Resident 266 was admitted March of 2025 and had diagnoses that included respiratory failure (is a serious condition that develops when the lungs can't get enough oxygen into the blood and makes it difficult for a person to breathe on his/her own) and chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing).<br><br>A review of Resident 266's admission History and Physical, dated 3/6/25, indicated Resident 266 was oriented to person, place and time, and Has the capacity to understand and make medical decisions.<br><br>A review of Resident 266's progress notes, dated 3/4/25, indicated Resident 266 arrived at the facility at around 11:30 a.m.<br><br>A review of Resident 266's physician's order, dated 3/4/25 at 2:33 p.m., indicated, Dulera [a prescription medicine used to control symptoms such as difficulty breathing] Inhalation Aerosol 200-5 MCG/ACT [micrograms/puff] .2 puff inhale orally two times a day related to CHRONIC OBSTRUCTIVE PULMONARY DISEASE .<br><br>A review of Resident 266's MAR for the month of March 2025, indicated Resident 266's dulera inhalation was scheduled to be administered every 9 a.m. and 5 p.m., with first dose on 3/4/25 at 5 p.m. A further review of the MAR indicated the dulera inhalation 5 p.m. dose on 3/4/25 and 9 a.m. dose on 3/5/25 were marked with a chart code, 5, which indicated the medications were held and not given to the resident.<br><br>A review of Resident 266's progress notes, dated 3/5/25 at 12:58 a.m., indicated, .some of the medication still to be delivered from pharmacy .<br><br>During an interview on 3/10/25 at 10:04 a.m. with Resident 266, Resident 266 stated she did not get all her medications when she was admitted . Resident 266 further stated she had some trouble breathing because she did not get one of her inhalers.<br><br>During a concurrent interview and record review on 3/11/25 at 4:22 p.m. with LN 6, Resident 266's MAR was reviewed. LN 6 confirmed that Resident 266's dulera inhalation on 3/4/25 at 5 p.m. and on 3/5/25 at 9 a.m. were not given. LN 6 stated there was a risk for Resident 266 to develop difficulty breathing when the dulera inhalation was not given.<br><br>During a concurrent phone interview and record review on 3/13/25 at 8:58 a.m. with the PPT, Resident 266's medication orders were reviewed. PPT stated they received Resident 266's medication order for dulera inhalation on 3/4/25 at 3:27 p.m., they needed additional authorization for high-cost medications from DON which they received on 3/4/25 at 11:36 p.m. and had filled and sent it on the next scheduled delivery time.<br><br>A review of the Shipping Manifest for Resident 266's dulera inhalation indicated the medication was received by the facility on 3/5/25 at 1:20 p.m.<br><br>1f. A review of Resident 60's clinical record indicated Resident 60 was admitted March of 2025 and had diagnoses that included thrombocytosis (a condition characterized by an abnormally high number of clotting components in the blood) and benign prostatic hyperplasia (BPH- the prostate gland grows larger than normal potentially causing urinary problems).<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of Resident 60's admission History and Physical, dated 3/5/25, indicated Resident 60 was oriented to person, place and time, but Does not have the capacity to understand and make medical decisions.<br><br>A review of Resident 60's progress notes, dated 3/5/25, indicated Resident 60 arrived at the facility on 3/4/25 at 3:05 p.m.<br><br>A review of Resident 60's physician's order, dated 3/4/25 at 4:40 p.m., indicated, Tamsulosin HCL [a medication used to treat enlarged prostate] Oral Capsule 0.4 MG . Give 1 capsule by mouth at bedtime related to BENIGN PROSTATIC HYPERPLASIA .<br><br>A review of Resident 60's physician's order, dated 3/4/25 at 4:43 p.m., indicated, Apixaban [a medication used to treat and prevent blood clots and to prevent stroke] Oral Tablet 2.5 MG . Give 1 tablet by mouth two times a day .<br><br>A review of Resident 60's MAR for the month of March 2025, indicated Resident 60's tamsulosin was scheduled to be administered starting 3/4/25 every 9 p.m. and the apixaban was scheduled every 9 a.m. and 9 p.m., with first dose on 3/4/25 at 9 p.m. A further review of the MAR indicated the 9 p.m. doses for tamsulosin and apixaban on 3/4/25 were marked with a chart code, 5, which indicated the medications were held and not given to the resident.<br><br>A review of Resident 60's progress notes, dated 3/5/25 at 6:56 a.m., indicated, .f/u [follow up] with pharmacy as medication not delivered.as per pharmacy they did not receive the face sheet and order. Refaxed all the order and face sheet. Requested stat [immediate] delivery of medication. endorsed to next shift .<br><br>During an interview on 3/11/25 at 4:08 p.m. with Resident 60, Resident 60 stated he could not remember if he got all his medications when he was admitted in the facility.<br><br>During a concurrent interview and record review on 3/11/25 at 4:22 p.m. with LN 6, Resident 60's MAR was reviewed. LN 6 confirmed that 9 p.m. doses of Resident 60's tamsulosin and apixaban on 3/4/25 were not given. LN 6 stated there was a risk for Resident 60 to develop impaired circulation when the apixaban was not given and a risk to negatively affect Resident 60's health when the tamsulosin was not given.<br><br>During a concurrent phone interview and record review on 3/12/25 at 11:51 a.m. with the PPT, Resident 60's medication orders were reviewed. PPT stated they only received Resident 60's medication orders for tamsulosin and apixaban on 3/5/25 at 4:18 a.m. and had filled and sent it on the next scheduled delivery time.<br><br>A review of the Shipping Manifest for Resident 60's tamsulosin and apixaban indicated the medications were received by the facility on 3/5/25 at 10:30 a.m.<br><br>1g. A review of Resident 267's clinical record indicated Resident 267 was admitted March of 2025 and had diagnoses that included asthma (a condition in which a person's airways become inflamed, narrow, and swell, and produce extra mucus, which makes it difficult to breathe) and gastro-esophageal reflux disease (GERD- a condition where stomach acid flows back up into the esophagus causing symptoms like heartburn and regurgitation).<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of Resident 267's admission History and Physical, dated 3/5/25, indicated Resident 60 was oriented to person, place and time, and Has the capacity to understand and make medical decisions.<br><br>A review of Resident 267's progress notes, dated 3/4/25, indicated Resident 267 arrived at the facility at around at 3 p.m.<br><br>A review of Resident 267's physician's order, dated 3/4/25 at 4:40 p.m., indicated, Fluticasone-Salmeterol Inhalation [a combination medication used to treat asthma] .500-50 MCG/ACT .1 puff inhale orally one time a day for asthma .<br><br>A review of Resident 267's physician's order, dated 3/4/25 at 6:29 p.m., indicated, Pantoprazole Sodium [a medication used to treat GERD] Oral Capsule 100 MG . Give 1 capsule by mouth two times a day for GERD .<br><br>A review of Resident 267's MAR for the month of March 2025, indicated Resident 267's fluticasone-salmeterol inhalation was scheduled to be administered starting 3/5/25 every 9 a.m. and the pantoprazole was scheduled every 6:30 a.m. and 4:30 p.m., with first dose on 3/5/25 at 6:30 a.m. A further review of the MAR indicated the 9 a.m. dose of fluticasone-salmeterol inhalation and 6:30 a.m. dose of pantoprazole for Resident 267 on 3/5/25 were marked with a chart code, 5, which indicated the medications were held and not given to the resident.<br><br>A review of Resident 267's progress notes, dated 3/5/25 at 4:19 p.m., indicated, Fluticasone spray unable to give, waiting for pharmacy delivery .<br><br>During an interview on 3/10/25 at 11:10 a.m. with Resident 267, Resident 267 stated she did not receive some of her medications when she was admitted in the facility. Resident 267 also stated it was upsetting for her to wait that long for her medications.<br><br>During a concurrent interview and record review on 3/11/25 at 4:22 p.m. with LN 6, Resident 267's MAR was reviewed. LN 6 confirmed the 9 a.m. dose of fluticasone-salmeterol inhalation and 6:30 a.m. dose of pantoprazole for Resident 267 on 3/5/25 were not given. LN 6 stated there was a risk for Resident 267 to develop gastric acidity when the pantoprazole was not given and a risk to develop difficulty breathing when the fluticasone-salmeterol inhalation was not given.<br><br>During a concurrent phone interview and record review on 3/12/25 at 11:51 a.m. with the PPT, Resident 60's medication orders were reviewed. PPT stated they only received Resident 267's medication orders for fluticasone-salmeterol inhalation and pantoprazole on 3/5/25 at 12:35 p.m. and had filled and sent it on the next scheduled delivery time.<br><br>A review of the Shipping Manifest for Resident 267's fluticasone-salmeterol inhalation and pantoprazole indicated the medications were received by the facility on 3/5/25 at 3:20 p.m.<br><br>During a phone interview on 3/13/25 at 9:15 a.m. with the Pharmacy Consultant (PC), the PC stated he would expect the facility would be able to provide all prescribed medications to newly admitted residents in a timely manner.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 3/13/25 at 9:28 a.m. with the Admissions Coordinator (AC), the AC stated the facility was having issues with faxing medication orders to their pharmacy. The AC further stated whenever they would follow-up with the pharmacy, the pharmacy would say they did not receive the faxed orders.<br><br>During an interview on 3/13/25 at 9:41 a.m. with the DON, the DON stated she would expect staff to fax medication orders to pharmacy immediately or at most an hour after the resident arrived in the facility so the pharmacy could send the medications right away. The DON further stated that she would expect that all medications for newly admitted residents are provided timely and in accordance with the physician's order.<br><br>A review of the facility's P&P titled, Administering Medications, revised 1/2025, indicated, Medications are administered in a safe and timely manner, and as prescribed .4. Medications are administered in accordance with prescriber orders, including any required time frame.<br><br>A review of the facility's P&P titled, Admission Assessment, revised 1/2025, indicated, It is the policy of the facility to admit and retain only residents it can adequately meet the needs and provide services to.<br><br>A review of the facility's P&P titled, Obtaining, Accepting and Delivery of Medications, revised 3/2025, indicated, 6. Orders from New Admissions will be verified with the Attending Physician for reconciliation and will be transcribed as ordered. 7. A copy of the transcribed orders will be faxed to the Pharmacy and the Nurse will call Pharmacy to verify if the faxed orders were received.<br><br>A review of the facility's P&P titled, Pharmacy Services, revised 1/2025, indicated, The facility shall accurately and safely provide or obtain pharmaceutical services, including the provision of routine and emergency medications .4. Residents have sufficient supply of their prescribed medications and receive medications (routine, emergency or as needed) in a timely manner.<br><br>17069<br><br>1h. During a review of Resident 28's Progress Note dated 1/31/25 at 3:35 p.m. indicated she was admitted to the facility on [DATE] around 12:30 p.m.<br><br>During a review of Resident 28's Order Summary Report for January 2025 contained a physician's order dated 1/31/25 for Fluticasone-Salmeterol Inhalation Aerosol Powder Breath Activated (to treat difficulty breathing and reduce swelling in the airways) one puff inhale two times a day.<br><br>Review of Resident 28's January 2025 MAR indicated the Fluticasone-Salmeterol Inhalation Aerosol Powder Breath Activated was to be given twice a day at 9 a.m. and 5 p.m. The MAR indicated on 1/31/25 at 5 p.m. the Licensed Nurse (LN) documented 5 in the initial box. Under the section Chart Codes on the MAR indicated 5=Hold/See Nurse Notes.<br><br>Review of a Progress Note (Type: eMAR Medication Administration Note)<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | dated 1/31/25 at 6:26 p.m. indicated Fluticasone-Salmeterol Inhalation Aerosol Powder Breath Activated 500-50 mcg (micrograms)/act (actuation) 1 puff inhale orally two times a day related to Chronic Obstructive Pulmonary Disease with (Acute) Exacerbation (lung disease that blocks airflow and makes it difficult to breathe) .New admit, wait for delivery.<br><br>Review of PharMerica Shipping Manifest Pharmaceuticals indicated the Fluticasone-Salmeterol Inhalation Aerosol Powder Breath Activated was delivered to the facility on [DATE] at 7:30 p.m.<br><br>During an interview on 3/11/25 at 10:32 a.m. with the Director of Nursing (DON), she stated 5 documented in the initial box on the MAR indicated a progress note was written by the LN. The DON stated the pharmacy makes deliveries to the facility everyday between 1:30 p.m.-2 p.m., 7 p.m.-8 p.m. and 11p.m.-1 a.m.<br><br>During a concurrent interview and record review on 3/11/25 at 11:16 a.m. with the DON, Resident 28's clinical record was reviewed. The DON confirmed Resident 28's Fluticasone-Salmeterol Inhaler was not given as ordered once the facility had received the medication from the pharmacy.<br><br>During a review of Resident 28's Order Summary Report for January 2025 contained a physician's order dated 1/31/25 for Pantoprazole Sodium Oral Suspension (used to treat heartburn and acid reflux) 10 ml (milliliters) via Peg-Tube (a tube inserted in the stomach used to administer nutrition and medications) two times a day.<br><br>Review of Resident 28's January 2025 MAR indicated the Pantoprazole Sodium was to be given twice a day at 9 a.m. and 5 p.m. The MAR indicated on 1/31/25 at 5 p.m. the LN documented 5 in the initial box.<br><br>Review of a Progress Note (Type: eMAR Medication Administration Note)<br><br>dated 1/31/25 at 6:26 p.m. indicated, Pantoprazole Sodium Oral Suspension 4 mg/ml give 10 ml via Peg-Tube two times a day related to Gastrointestinal Hemorrhage .New admit, wait for delivery.<br><br>Review of PharMerica Shipping Manifest Pharmaceuticals indicated the Pantoprazole Sodium was delivered to the facility on [DATE] at midnight.<br><br>During an interview on 3/11/25 at 10:32 a.m. with the DON, she stated 5 documented in the initial box on the MAR indicated a progress note was written by the LN. The DON stated the pharmacy makes deliveries to the facility everyday between 1:30 p.m.-2 p.m., 7 p.m.-8 p.m. and 11p.m.-1 a.m.<br><br>During a concurrent interview and record review on 3/11/25 at 11:16 a.m. with the DON, Resident 28's clinical record was reviewed. The DON confirmed Resident 28's Pantoprazole Sodium Oral Suspension was not given as ordered due to the medication was not delivered by the pharmacy until 2/1/25 at midnight.<br><br>During a review of Resident 28's Order Summary Report for January 2025 contained a physician's order dated 1/31/25 for Umeclidinium Bromide Inhalation Aerosol Powder Breath Activated (relaxes and opens the air passages in the lungs) one puff one time a day.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Resident 28's February 2025 MAR indicated the Umeclidinium Bromide Inhalation Aerosol Powder Breath Activated was to be given every day at 9 a.m. The MAR indicated on 2/1/25 and 2/2/25 at 9 a.m. the LN documented 5 in the initial box.<br><br>Review of a Progress Note (Type: eMAR Medication Administration Note)<br><br>dated 2/1/25 at 8:56 a.m. indicated, Umeclidinium Bromide Inhalation Aerosol Powder Breath Activated 62.5 MCG/ACT 1 puff inhale orally one time a day related to Chronic Obstructive Pulmonary Disease with (Acute) Exacerbation .Follow up with pharmacy.<br><br>Review of a Progress Note (Type: eMAR Medication Administration Note) dated 2/2/25 at 8:38 a.m. indicated, Umeclidinium Bromide Inhalation Aerosol Powder Breath Activated 62.5 MCG/ACT 1 puff inhale orally one time a day related to Chronic Obstructive Pulmonary Disease with (Acute) Exacerbation .Follow up with pharmacy, according to pharmacy staff ., it will be delivered today.<br><br>Review of PharMerica Shipping Manifest Pharmaceuticals indicated the Umeclidinium Bromide Inhalation Aerosol Powder was delivered to the facility on [DATE] at 1:25 p.m.<br><br>During an interview on 3/11/25 at 10:32 a.m. with the DON, she stated 5 documented in the initial box on the MAR indicated a progress note was written by the LN. The DON stated the pharmacy makes deliveries to the facility everyday between 1:30 p.m.-2 p.m., 7 p.m.-8 p.m. and 11p.m.-1 a.m.<br><br>During a concurrent interview and record review on 3/11/25 at 11:16 a.m. with the DON, Resident 28's clinical record was reviewed. The DON confirmed Resident 28's Umeclidinium Bromide Inhalation Aerosol Powder Breath Activated was not given as ordered due to it was not delivered by the pharmacy until 2/2/25 at 1:25 p.m.<br><br>1i. During a review of Resident 410's Progress Notes dated 2/13/25 at 6:08 p.m. indicated he was admitted to the facility on [DATE] around 4:08 p.m.<br><br>During a review of Resident 410's Order Summary Report for February 2025 contained a MD order dated 2/13/25 for Carbidopa-Levodopa Oral Tablet Disintegrating 25-250 mg two tablets four times a day.<br><br>Review of Resident 410's February 2025 MAR indicated the Carbidopa-Levodopa was to be given at 9 a.m., 1 p.m., 5 p.m., and 9 p.m. The MAR indicated on 2/13/25 at 9 p.m. and 2/14/25 at 9 a.m. and 1 p.m. the LN documented 5 in the initial box.<br><br>Review of Resident 410's Progress Note (Type: eMAR Medication Administration Note) dated 2/13/25 at 9:48 p.m. indicated Carbidopa-Levodopa Oral Table-c Disintegrating 25-250 mg Give 2 tablet by mouth four times a day related to Parkinsonism .Take 1 to 2 tabs extra tabs (tablet) daily than previously taken. Max 6 tablets per day Pending from pharmacy<br><br>Review of Resident 410's Progress Note (Type: eMAR Medication Administration Note) dated 2/14/25 at 10:49 a.m. indicated Carbidopa-Levodopa Oral Table-c Disintegrating 25-250 mg Give 2 tablet by mouth four times a day related to Parkinsonism .Take 1 to 2 tabs extra tabs (tablet) daily than previously taken. Max 6 tablets per day waiting for pharmacy delivery.<br><br>(continued on next page) |

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| | 055189 | A. Building<br>B. Wing | 03/13/2025 |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Resident 410's Progress Note (Type: eMAR Medication Administration Note) dated 2/14/25 at 2:48 p.m. indicated Carbidopa-Levodopa Oral Table-c Disintegrating 25-250 mg Give 2 tablet by mouth four times a day related to Parkinsonism .Take 1 to 2 tabs extra tabs (tablet) daily than previously taken. Mac 6 tablets per day will be given when available.<br><br>Review of PharMerica Shipping Manifest Pharmaceuticals indicated the Carbidopa-Levodopa was delivered to the facility on [DATE] at 8:30 p.m.<br><br>During an interview on 3/11/25 at 10:32 a.m. with the DON, she stated 5 documented in the initial box on the MAR indicated a progress note was written. The DON stated the pharmacy makes deliveries to the facility everyday between 1:30 p.m.-2 p.m., 7 p.m.-8 p.m. and 11p.m.-1 a.m.<br><br>During a concurrent interview and record review on 3/11/25 at 11:16 a.m. with the DON, Resident 410's clinical record was reviewed. The DON confirmed Resident 410's Carbidopa-Levodopa was not given as ordered on 2/13/25 and 2/14/25. The DON stated the medication had not been delivered by the pharmacy.<br><br>A review of the facility's P&P titled, Administering Medications, revised 1/2025, indicated, Medications are administered in a safe and timely manner, and as prescribed .4. Medications are administered in accordance with prescriber orders, including any required time frame.<br><br>A review of the facility's P&P titled, Admission Assessment, revised 1/2025, indicated, It is the policy of the facility to admit and retain only residents it can adequately meet the needs and provide services to.<br><br>A review of the facility's P&P titled, Obtaining, Accepting and Delivery of Medications, revised 3/2025, indicated, 6. Orders from New Admissions will be verified with the Attending Physician for reconciliation and will be transcribed as ordered. 7. A copy of the transcribed orders will be faxed to the Pharmacy and the Nurse will call Pharmacy to verify if the faxed orders were received.<br><br>A review of the facility's P&P titled, Pharmacy Services, revised 1/2025, indicated, The facility shall accurately and safely provide or obtain pharmaceutical services, including the provision of routine and emergency medications .4. Residents have sufficient supply of their prescribed medications and receive medications (routine, emergency or as needed) in a timely manner.<br><br>43238<br><br>2.On 3/10/25, a review of facility documents [TRUNCATED] |

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| F 0760<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some | Ensure that residents are free from significant medication errors.<br><br>47197<br><br>Based on observation, interview and record review, the facility failed to ensure four out of 31 sampled residents (Resident 265, 264, 160, and 266) were free from significant medication errors when Resident 265, 264, 160, and 266 did not receive prescribed pain medications in accordance with the physician's order.<br><br>These failures resulted in Resident 265, 264, 160, and 266 experiencing unnecessary pain and emotional distress which had negatively affected the residents' level of comfort, activity and sleep.<br><br>Findings:<br><br>1a. A review of Resident 265's clinical record indicated Resident 265 was admitted February of 2025 and had diagnoses that included fracture (a break in the continuity of a bone) of left humerus (upper arm bone), neuralgia (pain caused by irritation or damage to a nerve) and neuritis (inflammation of a nerve), and the need for assistance with personal care.<br><br>A review of Resident 265's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns, dated 3/2/25, indicated Resident 2665 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 10 out of 15 which indicated Resident 265 had a moderately impaired cognition (mental process of acquiring knowledge and understanding). A review of Resident 265's MDS Health Conditions, dated 3/2/25, indicated Resident 265 had frequently experienced pain or hurting which frequently made it hard for her to sleep at night, occasionally limited her participation in rehabilitation therapy sessions, and occasionally limited her day-to-day activities.<br><br>A review of Resident 265's progress notes, dated 2/19/25, indicated Resident 265 arrived at the facility on 2/19/25 at around 11:58 p.m. and has a pain level of 4/10 (numeric pain scale from 1 to 10; 1-3 is mild pain, 4-7 is moderate pain, 8-10 is severe pain).<br><br>A review of Resident 265's physician's order, dated 2/19/25 at 12:13 p.m., indicated, MS Contin [a strong medication used to treat moderate to severe pain] Oral Tablet Extended Release 30 MG [milligrams- unit of measurement] (Morphine Sulfate) Give 1 tablet by mouth every 8 hours for Pain management.<br><br>A review of Resident 265's care plan, initiated 2/19/25, indicated, At risk for pain or discomfort related to left humeral fracture due to ground fall at home. A review of Resident 265's care plan intervention, initiated 2/19/25, indicated, Administer pain meds as MD (Medical Doctor) ordered .MS Contin Oral Tablet .for Pain management.<br><br>A review of Resident 265's Medication Administration Record (MAR- a legal document used to record medications given to the residents), for the month of February 2025, indicated Resident 265's morphine sulfate was scheduled to be administered every 8 a.m., 4 p.m., and 12 midnight, with the first dose scheduled on 2/19/25 at 4 p.m. A further review of the MAR indicated the 4 p.m. dose of morphine sulfate on 2/19/25 was marked with a chart code 5, which indicated the medication was held and not given to the resident.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some | A review of Resident 265's Weights and Vitals Summary, dated 2/19/25 at 8:38 p.m., indicated Resident 265 had a pain level of 8 [severe pain].<br><br>During an interview on 3/10/25 at 9:42 a.m. with Resident 265, Resident 265 stated she did not receive her morphine medication on the day she was admitted in the facility. Resident 265 also stated her pain was so awful that day, it went to a level of 9 out of 10 (severe pain). Resident 265 further stated, Well, It [sleeping] was hard .I got hard time sleeping .I was in so much pain.<br><br>During a concurrent interview and record review on 3/11/25 at 4:22 p.m. with Licensed Nurse (LN) 6, Resident 265's MAR for February 2025 was reviewed. LN 6 confirmed that Resident 265's morphine sulfate was not given on 2/19/25 at 4 p.m. LN 6 stated there was a risk for Resident 265 to be in so much pain when the morphine sulfate was not given.<br><br>During a concurrent observation and interview on 3/11/25 at 4:55 p.m. with LN 6, the facility's Emergency Kit (Ekit- a supply of medication used for urgent needs of residents) was checked. LN 6 confirmed that oral morphine sulfate is not part of the facility's Ekit supplies.<br><br>During a concurrent phone interview and record review on 3/13/25 at 10:54 a.m. with the Pharmacist from the Facility's Pharmacy (PP), Resident 265's medication orders were reviewed. The PP stated they only received Resident 265's medication order for morphine sulfate on 2/19/25 at 7:41 p.m. and had filled and sent it on the next scheduled delivery time which was 10:30 pm.<br><br>During a concurrent interview and record review on 3/13/25 at 11:46 a.m. with the Admissions Coordinator (AC), Resident 265's medication records were reviewed. The AC showed a fax receipt indicating Resident 265's prescription order of morphine sulfate was sent to their pharmacy on 2/19/25 at 5:53 p.m. The AC confirmed the prescription order was faxed after the scheduled administration. The AC stated that sometimes it would take 4 hours for nurses to transcribe medication orders which causes the delay in faxing medication orders.<br><br>A review of the Shipping Manifest [receipt] for Resident 265's morphine sulfate indicated the facility received the medication on 2/19/25 at 10:35 p.m.<br><br>1b. A review of Resident 264's clinical record indicated Resident 264 was admitted February of 2025 and had diagnoses that included osteoarthritis (OA- a deteriorating disease that causes pain, stiffness, and swelling where two or more bones meet), pain in right hip, diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), neuropathy (a nerve condition that can cause pain, numbness, tingling, or weakness in the body), chronic pain syndrome (condition that involves persistent pain that lasts for weeks to years), and major depressive disorder (persistently depressed mood or loss of interest in activities, causing significant impairment in daily life).<br><br>A review of Resident 264's MDS Cognitive Patterns, dated 2/26/25, indicated Resident 264 had a BIMS score of 15 out of 15 which indicated Resident 264 had an intact cognition. A review of Resident 264's MDS Health Conditions, dated 2/26/25, indicated Resident 264 had frequently experienced pain or hurting which frequently made it hard for her to sleep at night, frequently limited her participation in rehabilitation therapy sessions, and frequently limited her day-to-day activities.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some | A review of Resident 264's physician's order, dated 2/19/25 at 3:06 p.m., indicated, Pregabalin [a drug used to treat nerve and muscle pain] Oral Capsule 150 MG [milligrams- unit of measurement] .Give 1 capsule by mouth two times a day related to PAIN IN RIGHT HIP .<br><br>A review of Resident 264's care plan, initiated 2/19/25, indicated, At risk for alteration in comfort/pain related to: recent fall with right hip pain, chronic back pain .DM . A review of Resident 264's care plan intervention, initiated 2/19/25, indicated, Administer pain meds as MD ordered .<br><br>A review of Resident 264's MAR, for the month of February 2025, indicated Resident 264's pregabalin was scheduled to be administered every 9 a.m. and 5 p.m., with the first dose on 2/19/25 at 5 p.m. A further review of the MAR indicated that Resident 264's dose of pregabalin on 2/19/25 at 5 p.m., 2/20/25 at 9 a.m. and 5 p.m., and 2/21/25 at 9 a.m. were all marked with a chart code 5, which indicated the medication was held and not given to the resident.<br><br>A review of Resident 264's progress notes, dated 2/20/25 at 2:19 p.m., indicated, Followed up with [name of facility pharmacy] about Pregabalin; no response from doctor for authorization. Additional message was left for doctor by pharmacy staff.<br><br>During an interview on 3/10/25 at 9:48 a.m. with Resident 264, Resident 264 stated she did not get all her medications on the first few days when she was admitted in the facility, including her pain medication. Resident 264 also stated her pain level was so bad which she rated at 10 (severe pain). Resident 265 further stated, I was hurting .I cannot move or do anything .so I just stayed here in the room on those days .I was just in bed because I can't do anything .I was not comfortable, I was in a lot of pain .I was so upset to wait that long for it [pain medication] .<br><br>During a concurrent interview and record review on 3/11/25 at 4:22 p.m. with LN 6, Resident 264's MAR for February 2025 was reviewed. LN 6 confirmed that Resident 264's pregabalin was held and not given on 2/19/25 at 5 p.m., 2/20/25 at 9 a.m. and 5 p.m., and 2/21/25 at 9 a.m. LN 6 stated there was a risk for Resident 264 to have her pain not relieved when the pregabalin was not given for four times.<br><br>During a concurrent observation and interview on 3/11/25 at 4:55 p.m. with LN 6, the facility's Ekit was checked. LN 6 confirmed that pregabalin is not part of the facility's Ekit supplies.<br><br>During a concurrent phone interview and record review on 3/12/25 at 11:51 a.m. with the Pharmacy Technician from the Facility's Pharmacy (PPT), Resident 264's medication orders were reviewed. PPT stated they only received Resident 264's valid prescription order for pregabalin from the doctor on 2/21/25 at 7:32 a.m. and had filled and sent it on the next scheduled delivery time.<br><br>During a concurrent interview and record review on 3/13/25 at 11:46 a.m. with the AC, Resident 264's medication records were reviewed. The AC stated Resident 264 came from a local hospital that sends medication orders to their pharmacy electronically in which they're having problems. The AC also stated that their nurse would then need to call their facility doctor to get the actual prescription order and fax it the pharmacy. The AC then confirmed that there was no valid prescription order for Resident 264's pregabalin that was faxed to the pharmacy on admission.<br><br>A review of the Shipping Manifest for Resident 264's pregabalin indicated the facility received the medication on 2/21/25 at 1:45 p.m.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some | 1c. A review of Resident 160's clinical record indicated Resident 160 was admitted March of 2025 and had diagnoses that included migraine (a neurological (relating to the nervous system) condition characterized by recurring headaches, often with throbbing pain, sensitivity to light and sound, and sometimes nausea or vomiting), DM with neuropathy (disease or dysfunction of one or more nerves, typically causing numbness or weakness in the hands and feet), muscle spasm (an involuntary and sudden contraction of a muscle), and anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities).<br><br>A review of Resident 160's admission History and Physical, dated 3/5/25, indicated Resident 160 Has the capacity to understand and make medical decisions and was a high risk for falls and Activities of Daily Living (ADL- normal daily functions required to meet basic needs) decline.<br><br>A review of Resident 160's physician's order, dated 3/3/25 at 12:46 p.m., indicated, Qulipta [a medication used to prevent episodic and chronic migraine headaches] Oral Tablet 60 MG . Give 1 tablet by mouth one time a day for migraine.<br><br>A review of Resident 160's care plan, initiated 3/4/25, indicated, At risk for pain or discomfort related to: . >migraine .>muscle spasm .>DM w/ neuropathy. A review of Resident 160's care plan intervention, initiated 3/4/25, indicated, Administer pain meds as MD ordered .Qulipta Oral Tablet .for migraine.<br><br>A review of Resident 160's MAR for the month of March 2025, indicated Resident 160's qulipta were scheduled to be administered starting 3/4/25 every 9 a.m. A further review of the MAR indicated the 9 a.m. dose of qulipta on 3/4/25 was marked with a chart code, 5, which indicated the medications were held and not given to the resident.<br><br>A review of Resident 160's Weights and Vitals Summary, indicated Resident 160 had pain levels as follows:<br><br>3/3/25 at 8:10 p.m.- 8 (severe pain),<br><br>3/3/25 at 10:05 p.m.- 8 (severe pain),<br><br>3/4/25 at 7:38 a.m.- 4 (moderate pain),<br><br>3/4/25 at 8:45 a.m.- 9 (severe pain),<br><br>3/4/25 at 3:47 p.m.- 8 (severe pain),<br><br>3/4/25 at 4:36 p.m.- 6 (moderate pain),<br><br>3/5/25 at 12:25 a.m.- 4 (moderate pain),<br><br>3/5/25 at 12:47 a.m.- 8 (severe pain),<br><br>3/5/25 at 5:22 a.m.- 8 (severe pain).<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some | A review of Resident 160's progress notes, dated 3/4/25 at 2:33 p.m., indicated, .following meds [medications were] not available to be given on time: .Qulipta 60 mg tabs. Pharmacy contacted and will [be] delivered ASAP.<br><br>During an interview on 3/11/25 at 2:17 p.m. with Resident 160, Resident 160 stated she needed to wait two days to get some of her medications when she was admitted , including her medication for migraines. Resident 160 also stated she had a migraine on those days and was very uncomfortable. Resident 160 further stated, I felt really bad not getting some of it .well, It's upsetting but what can I do .It [missing migraine medication] was not comfortable of course.<br><br>During a concurrent interview and record review on 3/11/25 at 4:22 p.m. with LN 6, Resident 160's MAR was reviewed. LN 6 confirmed that Resident 160's Qulipta was not given on 3/4/25 at 9 a.m. LN 6 stated there was a risk for Resident 160 to experience unrelieved migraine or pain when the Qulipta was not given.<br><br>During a concurrent phone interview and record review on 3/13/25 at 8:58 a.m. with the PPT, Resident 160's medication orders were reviewed. PPT stated they received Resident 160's medication order for Qulipta on 3/3/25 at 4:39 p.m., they needed additional authorization for high-cost medications from the (Director of Nurses) DON which they received on 3/4/25 at 9:30 p.m. and had filled and sent it on the next scheduled delivery time.<br><br>A review of the Shipping Manifest for Resident 160's Qulipta indicated the facility received the medication on 3/5/25 at 8:33 a.m.<br><br>1d. A review of Resident 266's clinical record indicated Resident 266 was admitted March of 2025 and had diagnoses that included neuralgia (nerve pain) and neuritis (inflammation of a nerve), osteoarthritis, and chronic pain.<br><br>A review of Resident 266's admission History and Physical, dated 3/6/25, indicated Resident 266 was oriented to person, place and time, Has the capacity to understand and make medical decisions, and was a high risk for fall and ADL decline.<br><br>A review of Resident 266's progress notes, dated 3/4/25, indicated Resident 266 arrived at the facility at around 11:30 a.m.<br><br>A review of Resident 266's physician's order, dated 3/4/25 at 2:33 p.m., indicated, Buprenorphine [a strong medication used to treat moderate to severe pain] HCl (Hydrochloric acid) Sublingual [below the tongue] Tablet Sublingual 8 MG . Give 1 tablet sublingually two times a day for Chronic pain.<br><br>A review of Resident 266's physician's order, dated 3/4/25 at 2:33 p.m., indicated, Pregabalin Oral Capsule 25 MG . Give 1 capsule by mouth two times a day related to NEURALGIA AN NEURITIS .<br><br>A review of Resident 266's care plan, initiated 3/4/25, indicated, At risk for pain or discomfort related to: .> NEURALGIA AND NEURITIS .> OA. >Chronic Pain. A review of Resident 160's care plan intervention, initiated 3/4/25, indicated, Administer pain meds as MD ordered .Buprenorphine HCl .Pregabalin Oral Capsule .<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some | A review of Resident 266's MAR for the month of March 2025, indicated Resident 266's buprenorphine and pregabalin were both scheduled to be administered every 9 a.m. and 5 p.m., with first dose on 3/4/25 at 5 p. m. A further review of the MAR indicated the 5 p.m. dose of buprenorphine on 3/4/25, and the pregabalin 5 p. m. dose on 3/4/25 and 9 a.m. dose on 3/5/25 were all marked with chart code, 5, which indicated the medications were held and not given to the resident.<br><br>A review of Resident 266's progress notes, dated 3/5/25 at 12:58 a.m., indicated, .some of the medication still to be delivered from pharmacy .<br><br>A review of Resident 266's Weights and Vitals Summary, indicated Resident 266 had pain levels as follows:<br><br>3/5/25 at 12:39 a.m.- 5 (moderate pain),<br><br>3/5/25 at 9:40 a.m.- 5 (moderate pain),<br><br>3/5/25 at 4:40 a.m.- 7 (moderate pain).<br><br>During an interview on 3/10/25 at 10:04 a.m. with Resident 266, Resident 266 stated she did not get all her medications when she was admitted , including her pain medications. Resident 266 also stated she had pain on the days she did not receive her pain medications which she rated at a level of 9 out of 10 (severe pain). Resident 266 further stated, I was in so much pain .I tried to rest but I could not sleep at all that night .It's [pain] so bad.<br><br>During a concurrent interview and record review on 3/11/25 at 4:22 p.m. with LN 6, Resident 266's MAR was reviewed. LN 6 confirmed that Resident 266's 5 p.m. dose of buprenorphine on 3/4/25, and the pregabalin 5 p.m. dose on 3/4/25 and 9 a.m. dose on 3/5/25 were not given. LN 6 stated there was a risk for Resident 266 to have uncontrolled pain when the buprenorphine and pregabalin was not administered.<br><br>During a concurrent phone interview and record review on 3/13/25 at 8:58 a.m. with the PPT, Resident 266's medication orders were reviewed. PPT stated they received Resident 266's medication order for buprenorphine from the facility on 3/4/25 at 3:27 p.m., they had to send the order to the doctor for approval and only received the valid prescription order for buprenorphine on 3/4/25 at 5:55 p.m. then they had filled and sent it on the next scheduled delivery time.<br><br>During a concurrent phone interview and record review on 3/13/25 at 10:54 a.m. with the PP, Resident 266's medication orders were reviewed. The PP stated they received Resident 266's medication order for pregabalin on 3/4/25 at 3:27 p.m. but the facility only sent discharge paper, which is not a valid prescription order, so they needed to fax it to the doctor on 3/4/25 at 6:57 p.m. for approval and only received the valid prescription order for pregabalin on 3/5/25 at 10:37 a.m. which then they had filled and sent it on the next scheduled delivery time which was 5:30 pm.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055189 | A. Building<br>B. Wing | 03/13/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Greenfield Care Center of Fairfield | 1260 Travis Blvd<br>Fairfield, CA 94533 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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|---|---|
| F 0760<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some | During a concurrent interview and record review on 3/13/25 at 11:46 a.m. with the AC, Resident 266's medication records were reviewed. The AC then confirmed that there was no valid prescription order for Resident 266's buprenorphine and pregabalin that was faxed to the pharmacy. The AC stated they're aware that controlled medications (medications with high potential for abuse or addiction) like buprenorphine and pregabalin needs a valid prescription order before the pharmacy dispense the medication.<br><br>A review of the Shipping Manifest for Resident 266's buprenorphine indicated the facility received the medication on 3/5/25 at 1 a.m.<br><br>A review of the Shipping Manifest for Resident 266's pregabalin indicated the facility received the medication on 3/5/25 at 7:10 p.m.<br><br>During a phone interview on 3/13/25 at 9:15 a.m. with the Pharmacy Consultant (PC), the PC stated he would expect the facility would be able to provide all prescribed medications to newly admitted residents in a timely manner, especially the pain medications which should be provided immediately. The PC also stated he was not aware the facility ' s Ekit did not contain oral morphine sulfate and pregabalin which were common pain medications.<br><br>During an interview on 3/13/25 at 9:41 a.m. with the DON, the DON stated she would expect staff to fax medication orders to pharmacy immediately or at most an hour after the resident arrived in the facility so the pharmacy could send the medications right away. The DON also stated that she would expect that all medications for newly admitted residents, especially pain medications, are provided timely and in accordance with the physician's order. The DON further stated that resident's pain should be addressed right away.<br><br>A review of the facility's policies and procedures (P&P) titled, Pain Management, revised 1/2025, indicated, To provide guidelines for consistent .management .of pain, in order to provide the maximum level of comfort and enhanced quality of life for residents having pain or at risk of having pain .2. The physician may order appropriate .medication intervention s to address the resident's pain.<br><br>A review of the facility's P&P titled, Administering Medications, revised 1/2025, indicated, Medications are administered in a safe and timely manner, and as prescribed .4. Medications are administered in accordance with prescriber orders, including any required time frame.<br><br>A review of the facility's P&P titled, Admission Assessment, revised 1/2025, indicated, It is the policy of the facility to admit and retain only residents it can adequately meet the needs and provide services to.<br><br>A review of the facility's P&P titled, Obtaining, Accepting and Delivery of Medications, revised 3/2025, indicated, 6. Orders from New Admissions will be verified with the Attending Physician for reconciliation and will be transcribed as ordered. 7. A copy of the transcribed orders will be faxed to the Pharmacy and the Nurse will call Pharmacy to verify if the faxed orders were received.<br><br>A review of the facility's P&P titled, Pharmacy Services, revised 1/2025, indicated, The facility shall accurately and safely provide or obtain pharmaceutical services, including the provision of routine and emergency medications .4. Residents have sufficient supply of their prescribed medications and receive medications (routine, emergency or as needed) in a timely manner. |

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|---|---|---|---|
| | 055189 | A. Building<br>B. Wing | 03/13/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Greenfield Care Center of Fairfield | 1260 Travis Blvd<br>Fairfield, CA 94533 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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|---|---|
| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43238<br><br>Based on observation, interview and record review, the facility failed to safely store medications when,<br><br>unused medications from a discharged resident (Resident 41) were stored in the bottom drawer of the Medication Cart C (Med Cart C) and an expired narcotic for Resident 15 found in the bottom drawer of Med Cart C.<br><br>These failures had the potential to contribute to unsafe medication use and storage, and potential for diversion.<br><br>Findings:<br><br>During a concurrent observation and interview on [DATE] at 3:24 p.m., Licensed Nurse 4 (LN 4) opened Med Cart C for inspection. The following medications were observed stored in the bottom drawer:<br><br>Pantoprazole (used to treat acid reflux and heartburn) 40 mg (milligrams, a unit of measure) tablets.<br><br>Nifedipine (used to treat high blood pressure and chest pain) 30 mg tablets.<br><br>Morphine Sulfate Oral Solution (used to treat moderate to severe pain) - Solution expired [DATE].<br><br>The LN 4 stated These [medications] should not be in here. I will remove them right now.<br><br>During an interview on [DATE], at 9:41 a.m., the Director of Nursing (DON) stated The expectation is [for LNs] to check expiration dates when doing counts. Any expired medication or medications from discharged residents should be removed from the cart. Two LNs should destroy non- narcotics, all narcotics should be surrendered to me to be placed in the lockbox.<br><br>During a record review of the facility's policy titled Labeling and Storing Medications, dated ,d+[DATE], indicated Medications no longer in use or medication which have expired will be disposed of in accordance with Federal and State Laws. |