

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055212	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/23/2024
NAME OF PROVIDER OR SUPPLIER  The Vineyards Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  76 Fenton Street Livermore, CA 94550	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47098</b></p> <p>Based on observation, interview, and record review, the facility failed to follow their policy and procedure for administering medications timely for one of three sampled residents (Resident 1), when Resident 1 ' s oral antibiotic medication (medication used to treat bacterial infections) was administered nine hours and sixteen minutes after it was ordered.</p> <p>This failure had the potential for exacerbating Resident 1 ' s health condition and compromising their overall health and well-being.</p> <p>Findings:</p> <p>During a review of Resident 1 ' s Administration Record (contains demographic and medical information), the administration record indicated, Resident 1 was admitted to the facility on [DATE], with diagnosis of COVID-19 (highly contagious respiratory disease), asthma (a chronic lung condition that makes it difficult to breathe) and hypertension (high blood pressure). Further review Resident 1 was discharged from the facility on February 25, 2024.</p> <p>During a review of Resident 1 ' s SBAR &amp; initial COC/Alert Charting &amp; Skilled Documentation (SBAR, a communication tool used in healthcare settings), dated, February 5, 2024 at 10:00 PM, it indicated, Resident 1 returned from the acute care hospital emergency department with discharge diagnosis of Pneumonia (an infection in the lungs that can make it hard to breath). SBAR further indicated Resident 1 had an order for Levofloxacin (antibiotic medication used to treat bacterial infections) 750 mg (milligrams unit of measure the dosage) by mouth daily for five days.</p> <p>During a review of Resident 1 ' s Physician Order dated, February 5, 2024, at 10:44 PM, documented by Licensed Vocational Nurse (LVN 1), the physician order indicated, an order for Resident 1 to receive Levofloxacin oral tablet 750 mg by mouth one time a day for pneumonia for five days.</p> <p>During a review of Resident 1 ' s Medication Administration Record for the month of February 2024, the medication administration record indicated Resident 1 received the first dose of Levofloxacin oral Tablet on February 6, 2024, at 8:00 AM (9 hours and 16 minutes after the medication was ordered).</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview, on April 23, 2024, at 10:06 AM, with the Director of Nurses (DON), inside the medication room, the DON stated the facility utilizes a Pyxis system (an electronic medication dispensing system) as an emergency kit (EKIT) for obtaining antibiotics when needed, and it is linked to the pharmacy. Specifically, the oral antibiotic Levofloxacin was observed to be available in both dosages 250 mg and 500 mg tablets.</p> <p>During a concurrent interview and record review on April 23, 2024, at 10:26 AM with the DON, the DON reviewed Resident 1 ' s physician order for Levofloxacin, dated February 5, 2024, at 10:44 PM and stated the order should have been carried out within four hours. The DON agreed that the nurse who received Resident 1 ' s order failed to follow the physician ' s order.</p> <p>During a concurrent interview and record review on April 23, 2024, at 1:22 PM with (LVN 1), LVN 1 reviewed Resident 1 ' s Physician Order for Levofloxacin dated February 5, 2024, at 10:44 PM, stated the order should be carried out immediately.</p> <p>During further interview and record review, on April 23, 2024, at 1:24 PM, with LVN 1, LVN 1 reviewed Resident 1 ' s Medication Administration Record (MAR) for the month of February 2024, and acknowledged that Resident 1 ' s Levofloxacin was not given timely. LVN 1 further stated not administering the available medication on time would delay Resident 1 ' s treatment for pneumonia.</p> <p>During a concurrent phone interview and record review on April 24, 2024, at 12:33 PM with the DON, DON reviewed the facility ' s policy and procedure (P&amp;P) titled, Administering Medications, dated April 2019. The P&amp;P indicated, .7. Medications are administered within (1) hour of their prescribed time, unless otherwise specified . The DON stated the policy was not followed. The DON further stated her expectation was for the licensed nurse to administer the medication within four hours, if the medication is available.</p> <p>Based on observation, interview, and record review, the facility failed to follow their policy and procedure for administering medications timely for one of three sampled residents (Resident 1), when Resident 1's oral antibiotic medication (medication used to treat bacterial infections) was administered nine hours and sixteen minutes after it was ordered.</p> <p>This failure had the potential for exacerbating Resident 1's health condition and compromising their overall health and well-being.</p> <p>Findings:</p> <p>During a review of Resident 1's Administration Record (contains demographic and medical information), the administration record indicated, Resident 1 was admitted to the facility on [DATE], with diagnosis of COVID-19 (highly contagious respiratory disease), asthma (a chronic lung condition that makes it difficult to breathe) and hypertension (high blood pressure). Further review Resident 1 was discharged from the facility on February 25, 2024.</p> <p>(continued on next page)</p>		

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