STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055412	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vacaville Ranch Post Acute	101 S Orchard Ave Vacaville, CA 95688

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 39792 Based on observation and interview the facility did not ensure one of one sampled (Resident 6) residents had her preferences honored when she wanted to get out of bed to have meals and was not assisted. This failure had the result of not being able to enjoy meals while out of bed, reduced respiratory exercise from not getting out of bed and increased skin breakdown by staying in bed all day. Findings: During an interview on 7/8/24 at 11:05 a.m., Resident 6 indicated she liked to get out of bed and have meals in her wheelchair in her room or in the dining room, and the facility had not been helping her to get out of bed for her meals. During a concurrent observation and interview on 7/8/24 at 12:46 p.m., Resident 6 was being assisted to sit up in bed by two staff members so she would be able to eat lunch more comfortably in bed. Unlicensed Staff F indicated Resident 6 usually got up to have meals in the dining room but did not that day and could not explain why. During an observation on 7/9/24 at 1 p.m., Resident 6 was sitting in her bed with her lunch tray finished on the bedside table in front of her. Resident 6 indicated she did not get out of bed to have lunch and shrugged her shoulders as if she did not know why. During an observation on 7/10/24 at 11:30 a.m., Resident 6 was laying in her bed, and the lunch trays had not delivered yet. At 1:30 p.m., Resident 6 indicted she did not get out of bed to have lunch; she ate in her bed and pointed downward on the bed. During an interview on 7/11/24 at 9:41 a.m., Unlicensed Staff H indicated Resident 6 usually got up for lunch but did not get on 7/8/24, because Unlicensed Staff H was not working that day. During an observation on 7/11/24 at 12:55 p.m., Resident 6 was sitting in her wheelchair, next to her bed having lunch. During an interview with Licensed Staff A, Licensed Staff A indicated Resident 6 usually got up but could not explain why Resident 6 had not been out of bed on 7/8/24, 7/9/24 and 7/10/24.

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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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41175 Based on observation, interview, and record review, the facility failed to provide prescribed medications, as ordered, for two of two sampled residents (Residents 153 and Resident 208), when: 1. Resident 153's Spiriva (an inhaled medication used to treat Chronic Obstructive Pulmonary Disease) was unavailable in the facility for four days; and, 2. Nine of nine scheduled medications (medications to be administered at a specific time) for Resident 208 were administered one hour and forty-five minutes past the scheduled administration time. These failures resulted in: 1. Resident 153 feeling anxious and increased the potential for an exacerbation of her chronic respiratory disease, which may have led to breathing difficulties, increased coughing, fatigue, and trouble sleeping or doing daily activities. 2. The potential to cause discomfort and/or jeopardize the health and safety of Resident 208. Findings: 1. During an interview on 7/8/24 at 3:48 p.m., Resident 153 stated she took inhaler medications at home. A review of Resident 153's, Face Sheet, indicated she was admitted to the facility on [DATE], with diagnoses that included chronic heart failure (a long-term condition that occurs when the heart cannot pump blood well enough to give the body a normal supply), Chronic Obstructive Pulmonary Disease (inflammatory lung disease that causes obstructed airflow from the lungs), muscle weakness and depression. During a concurrent observation and interview on 7/10/24 at 4:42 p.m., Resident 153 stated she had not been getting her Spiriva inhaler since admission. Resident 153 stated she notified the nurses about her use of the Spiriva medication at home but was told by the staff that the medication was, not available yet. Resident 153 appeared mildly distressed, occasionally grimacing throughout the interview, and frequently pausing as if to catch her breath. A review of Resident 153's, Orders History, indicated an order for, Spiriva Respimat Inhalation Aerosol Solution 2.5 MCG/ACT 2 puff inhale orally in the morning, with a Start Date of 7/8/24. A concurrent review of Resident 153's, Medication Administration Record (MAR), dated, 7/1/24-7/31, indicated the following entries for Spiriva: 7/8/24 = 4, 7/9/24 = 9, 7/10/24 = 9, and 7/11/24 = 9. Further review of the MAR indicated, Chart Codes . 4 = Vitals Outside of Parameters for Administration . 9 = Other/See Progress Notes. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 7/11/24 at 8:21 a.m., Resident 153 was lying in bed with an oxygen cannula on her nose. The oxygen tank displayed it was running at one lpm (liters per minute). Resident 153 stated she has had shortness of breath since the previous evening. During a concurrent interview and record review on 7/11/24 at 11:32 a.m., Licensed Staff C stated she did not give Resident 153 her Spiriva dose this morning because it was still awaiting delivery from the pharmacy. Upon review of Resident 153's MAR, Licensed Staff C stated Resident 153 did not receive four doses of Spiriva. Licensed Staff C stated she did not even realize Resident 153 had not been receiving her Spiriva since her admission. During a concurrent interview and record review of Resident 153's MAR on 4/12/24 at 9:12 a.m., Licensed Staff A stated Resident 153 missed four doses of the ordered Spiriva. Licensed Staff A stated nurses were expected to notify the Physician of missed medication doses, follow-up with the pharmacy, or if possible, check with the resident or their family if they could bring the medications from home until the ordered ones were delivered by the pharmacy. Licensed Staff A stated there was no documentation of these actions taken by the nurses after being unable to provide the Spiriva. Licensed Staff A stated the primary nurse should have reached out to the pharmacy regarding the delayed delivery. During an interview on 4/12/24 at 9:26 a.m., Pharmacist Consultant J stated it was his expectation that medications ordered for residents should be provided. When asked about the delayed delivery of Resident 153's Spiriva resulting in her to miss four doses, Pharmacist Consultant J stated the urgency needed to be there, and he expected better communication between the staff and the pharmacy. Pharmacist Consultant J stated while it was hard to say what caused Resident 153's recent shortness of breath; her being off the inhaler for several days could possibly have been a factor. A review of the facility policy titled, Medication Ordering and Receiving from Pharmacy, dated March 2018, indicated, Medications and related products are received from the dispensing pharmacy on a timely basis . Timely delivery of new orders is required so that medication administration is not delayed . 48660 2. During an observation on 7/10/24 at 10:43 AM, Licensed Staff E administered Enoxaparin 40 MG/0.4 ML Subcutaneous Injection to Resident 208. Record Review of a document titled, Medication Administration Audit Report, for Resident 208, dated 7/8/24-7/10/24, indicated the following scheduled times of administration and the actual times the medications were given: On 7/10/24, Polyethylene Glycol 3350 Powder, give 15 grams by mouth in the morning for Bowel Regulation, scheduled for 9 AM, and administered at 10:45 AM. On 7/10/24, Lasix Oral Tablet 20 MG, give one tablet by mouth two times a day related to HEART FAILURE, scheduled for 9 AM and administered at 10:45 AM. On 7/10/24, Carvedilol Oral Tablet 3.125 MG, give one tablet by mouth two times a day related to ESSENTIAL PRIMARY HYPERTENSION, scheduled for 9 AM and administered at 10:45 AM. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/10/24, Folic Acid Oral Tablet 1 MG, give one tablet by mouth in the morning for supplement, scheduled for 9 AM and administered at 10:45 AM. On 7/10/24, Ferrous Sulfate Oral Tablet 325 (65FE) MG, give one tablet by mouth in the morning related to ANEMIA, scheduled for 9 AM and administered at 10:45 AM. On 7/10/24, Ascorbic Acid Oral Tablet 500 MG, one tablet by mouth in the morning for supplement, scheduled for 9 AM and administered at 10:44 AM. On 7/10/24, Enoxaparin Sodium Injection Solution Pre-filled Syringe 40 MG/0.4 ML, inject 0.4 ML subcutaneously in the morning for DVT prophylaxis, scheduled for 9 AM and administered at 10:44 AM. On 7/10/24, Amiodarone HCl Oral Tablet 200 MG, give one tablet by mouth in the morning related to PAROXYSMAL ATRIAL FIBRILLATION, scheduled for 9 AM and administered at 10:44 AM. On 7/10/24, Finasteride Oral Tablet 5 MG, give one tablet by mouth in the morning related to BENIGN PROSTATIC HYPERPLASIA WITH LOWER URINARY TRACT SYMPTOMS, scheduled for 9 AM and administered at 10:45 AM. During an interview on 7/12/24 at 11:20 AM, Licensed Staff A stated medication administration time was one hour before and one hour after the scheduled time. During a concurrent interview and record review on 7/12/24 at 1:25 PM with Licensed Staff A, the Medication Administration Audit Report for Resident 208, dated 7/10/24, was reviewed. The Medication Administration Audit Report indicated all medications scheduled for 9 AM were administered at 10:44 AM or 10:45 AM. Licensed Staff A stated, all of the medications were administered late. During a review of the facility's policy and procedure titled, Medication Administration, dated March 2018, indicated, Medications are administered within 60 minutes of scheduled time .Unless otherwise specified by the prescriber, routine medications are administered according to the established medication administration schedule for the facility.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41175 Based on interview and record review, the attending Physician failed to document that he or she reviewed the Pharmacist's findings and/or failed to document the action taken or not taken to address said recommendations for a period of five months (February 2024 to June 2024). This failure has the potential for all 49 vulnerable residents to experience adverse consequences from medication use, such as errors due to drug-drug interactions, omissions, duplication of therapy, or miscommunication between care providers. Findings: During a record review of the MRR Binder on 7/10/24 at 3:16 p.m., the Medication Regimen Review (MRR) reports by the Pharmacist included a form titled, Note to Attending Physician/Prescriber, which contained the Pharmacist's recommendations. At end of the notes included a section titled, Physician/Prescriber Response, with three boxes labeled, Agree, Disagree, and Other, and blank lines. Further review of the reports indicated: [DATE], had six recommendations, [DATE], had eight, [DATE], had four, MAY 2024, had three, and JUNE 2024, had five recommendations. All 26 notes revealed blank Physician/Prescriber Response sections. During an interview and concurrent review of the MRR on 7/10/24 at 4:35 p.m., Licensed Staff A confirmed the Physician/Prescriber Response sections for the 26 Pharmacist recommendations were empty. Licensed Staff A stated the current process was a verbal discussion of the recommendations between her and the Physician. Licensed Staff A stated, if the Physician agreed with the recommendation, the medication would be added, removed or changed. Licensed Staff A stated, if the Physician did not agree with the recommendation, she would write a Progress Note in the resident's chart about the discussion. Licensed Staff A stated there was no documentation of any rationale of the Physician's disagreement with the recommendation. Licensed Staff A described the process as, unclear, and stated it did not show that the Physician was responding to the Pharmacist's recommendations. During an interview on 7/12/24 at 9:26 a.m., Pharmacist Consultant J stated sometimes it took a while for the Physicians to respond to his recommendations. A review of the facility policy titled, Consultant Pharmacist Reports IIIA-1 Medication Regimen Review (Monthly Report), dated March 2018, indicated, .G. Recommendations are acted upon and documented by the facility staff or the prescriber. 1) Physician accepts and acts upon suggestion or rejects and provides an explanation for disagreeing .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 48660 Based on observation, interview, and record review, the facility failed to ensure expired medications were immediately removed from stock and disposed of, when six bottles of medication were in the medication storage room two months after their expiration date. This failure had the potential to expose residents to medications that were less effective or risky due to a decrease in strength or a change in chemical composition. Findings: During a concurrent observation and interview on 7/10/24 at 7:42 AM, with Licensed Staff A in the medication storage room, six 473 ML bottles of Docusate Sodium 50 MG/5 ML had expired 5/2024. Licensed staff A verified the six bottles of Docusate Sodium had expired 5/2024. During an interview on 7/10/24 at 1:40 PM, Licensed Staff A stated expiration dates of medication stored in the medication storage room had been checked at least once per month by the AM (morning shift) Unit Manager. Licensed Staff A further stated the six bottles were stored on a higher shelf and had been overlooked. During a review of the facility's policy and procedure titled, Medication Storage in the Facility, dated March 2018, indicated, Outdated, contaminated, or deteriorated medications .are immediately removed from stock, disposed of according to procedures for medication disposal .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 39792 Based on observation, interview, and record review, the facility failed to follow guidelines for standard precautions (infection prevention practices that apply to all residents. Standard precautions are based on the principal that all blood, body fluids, secretions .may contain transmissible infectious agents. Standard precautions include hand hygiene .), when one licensed staff did not perform hand hygiene (refers to hand washing, antiseptic hand wash, and alcohol-based hand rub) during: 1. the administration of medications for two of five sampled residents (Residents 14 and 209); and, 2. prior to one of one sampled residents (Resident 9) eating her meal. These failures had the potential to expose residents to infectious agents causing illness and potentially death. Findings: 1. During medication administration observation on 07/10/24 at 8:26 AM, with Resident 14, Licensed Staff D did not perform hand hygiene before preparing medications, before entering the room, or after leaving the room. During medication administration observation on 07/10/24 at 12:16 PM, with Resident 209, Licensed Staff D did not perform hand hygiene before preparing medications, before entering the room, or after leaving the room. During medication administration observation on 07/10/24 at 12:20 PM, with Resident 14, Licensed Staff D did not perform hand hygiene before preparing medications, before entering the room, or after leaving the room. During an interview on 07/11/24 at 10 AM, Licensed Staff B stated staff washed hands anytime during medication administration if hands were visibly soiled. Licensed Staff B further stated an alcohol-based hand rub was used when entering a resident room and when leaving a resident room. During an interview on 07/12/24 at 11:20 AM, Licensed Staff A stated staff washed hands anytime during medication administration if hands were visibly soiled. Licensed Staff A further stated an alcohol-based hand rub was used before medication administration and between each resident. 2. During an observation on 7/8/24 at 12:05 p.m., Unlicensed Staff G was assisting in passing the lunch meal to residents who wished to eat in the dining room. This was the first lunch trays to be passed out to the residents. During a concurrent observation and interview on 7/28/24 at 12:28 pm., Resident 6 was laying in bed, and there was no lunch tray on her bedside table. When asked if she had eaten lunch, she indicated, No and indicated the staff would get her up to eat lunch in her wheelchair. During an observation on 7/8/24 at 12:44 p.m., Unlicensed Staff G took the meal cart over from the Dietary Staff for the residents on the hallway which included Resident 6's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 7/8/24 at 12:46 p.m., two Unlicensed Staff members entered Resident 6's room with her lunch meal and repositioned Resident 6 so she could sit up in bed more comfortably to have lunch. Unlicensed Staff F assisted with Resident 6's meal tray, and there was no hand hygiene used by Unlicensed Staff F while setting up Resident 6's meal tray. Unlicensed Staff F was asked if there were hand hygiene wipes on the meal trays for residents to clean their hands. Unlicensed Staff F indicated the meal trays were not served with hand hygiene wipes; the staff had already provided hand hygiene to Resident 6 before the meals was delivered. Unlicensed Staff F could not provide a name of who had provided hand hygiene to Resident 6, but that it was usually done before the meal trays were provided to the residents. Unlicensed Staff F indicated the residents' hands were cleaned with wipes which were located in the dining room. Unlicensed Staff F indicated the dining room had multiple canisters where staff would take a canister and then proceed to wash the residents' hands prior to meals being served. During a review of a policy and procedure titled, Handwashing/Hand Hygiene, dated August 2015, the policy indicated in Step 7, Use an alcohol-based hand rub .or, alternatively, soap and water for the following situations: before and after direct contact with residents and before preparing or handling medications. During a review of the facility's policy and procedure titled, Handwashing/Hand Hygiene, dated 8/2015, indicated .7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: .P. Before and after assisting a resident with meals. 48660

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 41175 Based on interview and record review, the facility failed to implement its policies and procedures on antibiotic stewardship, when two of 18 residents, who acquired Urinary Tract Infections (UTIs), were prescribed antibiotics prior to the results of a culture sensitivity test (Residents 34 and 31). [A culture sensitivity test is a test to find germs, such as bacteria or a fungus, that can cause an infection. A sensitivity test checks to see what kind of medicine, such as an antibiotics, will work best to treat the illness or infection]. This failure resulted in the inappropriate use of antibiotics and increased the risk for Residents 34 and 31 to develop multi-drug-resistant organisms and other antibiotic-related complications. Findings: During an interview on 7/11/24 at 9 a.m., Licensed Staff B stated the facility tracked the residents' antibiotic use and followed the McGreer Criteria for UTIs (a clinical criteria designed for the surveillance, diagnosis, and appropriate antibiotic use for UTIs in long-term care facilities). Licensed Staff B stated residents suspected of having a UTI should have at least one sign/symptom sub criteria and have urine culture sensitivity test results prior to starting antibiotics. During a concurrent review of the binder labeled, Surveillance Data Collection - Infection Control, Licensed Staff B stated Resident 34 had dysuria (painful urination) and was ordered Macrobid 100 mg (milligrams) for three days prior to receipt of the urine test results. Licensed Staff B stated Resident 34's test results later revealed no growth was detected on her urine culture, meaning there was no evidence of infection. When asked if Resident 34 met the criteria for antibiotic use, Licensed Staff B stated, No. Further review of the binder revealed Resident 31 received Keflex (a brand name of the antibiotic Cephalexin) 500 mg every six hours for seven days after he reported pain in the lower abdomen area and his catheter had purulent (containing pus) discharge. Licensed Staff B stated Resident 31's urine culture later had growth of Pseudomonas aeruginosa (a bacteria that is resistant to Cephalexin). When asked if Resident 31 met the criteria for antibiotic use, Licensed Staff B stated, No. Licensed Staff B stated the facility would not want to start residents on antibiotics if it would not work on the bacteria causing their infection, and added that the inappropriate use of antibiotics could result in multi-drug-resistant organisms. During an interview on 7/11/24 at 2:05 p.m., Medical Director I stated, waiting for the results of culture sensitivity testing was needed before Physicians could start residents on an antibiotic. Medical Director I stated, residents developing MDROs was a risk with the use of the wrong antibiotics. A review of the facility policy titled, Antibiotic Stewardship - Orders for Antibiotics, dated December 2016, indicated, Antibiotics will be prescribed and administered to residents under the guidance of the facility's Antibiotic Stewardship Program and in conjunction with the facility's general policy for Medication Utilization and Prescribing . Appropriate indications for use of antibiotics include: a. Criteria met for clinical definition of active infection or suspected sepsis; and b. Pathogen susceptibility, based on culture and sensitivity, to antimicrobial .