STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055499	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rocky Point Care Center	625 16th Street Lakeport, CA 95453

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)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the licensed nurses failed to ensure residents were free from significant medication errors for three residents (Resident 6, 32, and 8) of 10 sampled residents when:1. Residents 6 and 32 were not administered insulin pen injections as per manufacturer's instructions and;2. Resident 8 was not administered rifaximin (a medication used to kill bacteria that produces ammonia in the intestines and prevents toxins from reaching the brain and causing confusion or severe personality changes) for 36 doses.These failures placed the residents at risk for avoidable adverse clinical outcomes including uncontrolled blood glucose levels and exacerbation of liver disease.Findings:1. During a concurrent interview and medication pass observation on [DATE] at 8:17 a.m., Licensed Nurse 2 (LN 2) administered 20 units of glargine (long-acting insulin which provides steady 24-hr blood sugar control) via an insulin pen to Resident 32's right lower abdomen. LN 2 injected the insulin and removed the pen immediately. LN 2 did not maintain the needle in place as instructed by the manufacturer. LN 2 stated he was nervous and thought he had held the pen to Resident 32's skin.During a concurrent interview and medication pass observation on [DATE] at 4:13 p.m., LN 5 administered 4 units of lispro (fast acting insulin with a rapid onset and short duration) into Resident 6's left abdomen. LN 5 did not maintain the needle in place for the required duration, withdrawing the pen 5seconds after injection. LN 5 stated she was aware she pulled the pen away from Resident 6's skin slightly earlier than required.During an interview on [DATE] at 11:30 a.m., the DON acknowledged insulin pens required a certain duration held against the skin to ensure full insulin dose had been given. The DON stated an in-service was provided by the Pharmacy Consultant (PhC) in June of 2025 which covered this amongst other topics. This was not a mandatory in-service, but strongly recommended.During a phone interview on [DATE] at 1:51 p.m., the PhC stated he reviewed insulin pen administration during his in-service. The PhC stated he informed the licensed staff the insulin pens needed to stay intact on the skin for 6-10 seconds, depending on the type of insulin given; longer acting insulins require at least 10 seconds of hold time, shorter acting insulins can be removed after 6 seconds of hold time. The PhC stated removing the pen too early can result in underdosing the resident, possibly causing a spike in blood sugar levels.2. A review of Resident 8's admission record indicated admission to the facility on [DATE] with diagnoses of Alcoholic Cirrhosis (the final, most severe stage of alcohol associated liver disease characterized by extensive, irreversible scarring of the liver due to years of excessive drinking) andPortal Hypertension (elevated blood pressure within the portal system, which carries blood from the digestive system to the liver; usually caused by the scarring of the liver, which blocks blood flow, resulting in increased pressure).A review of Resident 8's physician orders, dated [DATE], indicated Resident 8 had an order to receive 550 milligrams (mg- a unit of measure) of rifaximin by mouth two times a day for prophylaxis (a treatment used to prevent the onset or spread of a disease) for hepatic encephalopathy (a reversible, serious decline in brain function due to severe liver disease).A review of the Medication Administration Record (MAR) key indicated the number 9 signified medication not available. A review of Resident 8's MAR dated February 2026 indicated 15 entries marked with a 9 for the ordered medication rifaximin, indicating the medication was not available and therefore not administered. A review of the MAR dated [DATE] (continued on next page)

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	presented an additional 14 missed doses of rifaximin, also documented with the 9 code. Seven doses were checked off as administered on [DATE],4,7,8,9 in between several days of medication not being administered. During an interview in Resident 8's room on [DATE]at 10:24 a.m., Resident 8 stated the facility stopped giving him his liver medication about one month ago because it was too expensive. He stated the facility is also giving him other medication to treat his liver disease, but that it is only part of his full treatment. Resident 8 stated he was worried his ammonia level was rising and that he was already starting to feel weird and falls asleep at abnormal times during the day. During an interview at the south nursing station on [DATE] at 8:04 a.m., LN 4 stated physician (MD) notification would be placed in the progress notes.A review of Resident 8's progress notes did not indicate any notification to either Resident 8's MD or the Director of Nursing (DON) regarding the critical missing medication.During an interview in the DON's office on [DATE] at 8:18 a.m., the DON stated she became aware of Resident 8 not receiving his rifaximin treatment at the beginning of the month when she received an authorization from the pharmacy for the rifaximin. The DON stated she called the pharmacy to escalate the urgency and notified the MD. The DON stated the physician increased Resident 8's lactulose (medication used to reduce blood ammonia levels in liver disease) on [DATE]. The DON further stated she understood the critical nature of obtaining this medication and has reached out to the pharmacy on at least four occasions. She was told they needed authorization to proceed with ordering the medication. She stated she was working with the MD and the pharmacy to expedite the process. The DON confirmed there were no nursing progress notes to indicate MD notification. She further confirmed the seven doses documented as given on Resident 8's MAR was documented in error. The rifaximin has not been issued from the pharmacy since [DATE]. The DON confirmed the total missed doses of rifaximin was 36. The DON also confirmed the nursing staff should have notified the MD and herself about the missing rifaximin.During an interview in room [ROOM NUMBER] on [DATE] at 10:21 a.m., the MD stated, If [Resident 8] does not get his rifaximin, he will die. He [Resident 8] is on the maximum dose of lactulose at 45 milliliters four times daily. There is nothing more we can do to stop the decline. We need the medication [rifaximin].During a phone interview on [DATE] at 1:51 p.m., the PhC stated he became aware of the situation with Resident 8 earlier that morning while speaking with the DON. He stated Resident 8's prior authorization for the medication had expired, and the physician needed to justify the prescription. When that task was completed, the pharmacy would submit to Resident 8's insurance plan for approval. The whole process should take 2-3 days.A review of facility policy titled Adverse Consequences and Medication Errors, revised 2/2025, indicated the facility, monitors medication usage in order to prevent and detect medication related problems.A medication error is defined as.the administration of drugs which is not in accordance with physicians orders.or accepted professional standards.examples of medication errors include: omission- a drug is ordered but not administered.failure to follow.accepted professional standards.promptly notify the provider [physician] of any significant error.