STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055846	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Terraces at San Joaquin Gardens Village	5551 N. Fresno St Fresno, CA 93710

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38961 Based on interview, and record review, the facility failed to ensure one of six sampled residents (Resident 1) received treatment and care in accordance with professional standards of practice when Licensed Vocational Nurse (LVN) 1 discharged Resident 1 home with seven medications which belonged to Resident 2. This failure resulted in Resident 1 not being administered her prescribed blood pressure medications for four days as prescribed by the physician and placed Resident 1 at risk for adverse effects of medication. Findings: During a review of Resident 1 ' s Admission Record (AR-a document with person identifiable and medical information), dated, 05/30/24 the AR indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses which included Type 2 Diabetes Mellites (body has trouble controlling blood sugar), hypertensive heart disease (heart problems that develop over time in people with long term high blood pressure), Hyperlipidemia, (abnormally high levels of lipids (fatty acids), Osteoarthritis (a progressive degradation of bone and joints). During a review of Residents 1 ' s Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive and physical function) assessment dated [DATE], indicated Resident 1 ' s Brief Interview of Mental status assessment (BIMS - assessment of cognitive status for memory and judgement) scored 11 of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment). The BIMS assessment indicated Resident 1 was moderately impaired. During a concurrent interview and record review on 05/30/24, at 10:00 a.m. with Administrator, (ADM), Resident 1 ' s Medication Disposition Form. (MDF) dated 05/02/24 was reviewed. The ADM stated, MDF is the form used to list all medications provided to residents discharging from facility. The ADM stated, the name and medications listed on the MDF were for another resident [Resident 2]. The ADM stated, Resident 1 ' s FM signed the form with LVN 1 indicating the medications being provided. The ADM stated, LVN 1 ' s signature on the form indicates medications were reviewed with FM and the right medications were provided to the right resident. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/30/24, at 10:10 a.m., with LVN 2. LVN 2 stated, Staff were able to provide medications to residents being discharged home. LVN 2. Resident medication list are updated daily, and when removing medication from medications cart we verify the medication list to the medications coming out of the medication cart. LVN 2 stated, the five rights of medication rights should be followed when providing medications to discharging residents (right resident, right medication, right dosage, rights route, and right time). LVN 2 stated, staff should validate the medication orders and compare to the most recent Medical Doctor (MD) orders for accuracy. LVN 2 stated, LVN ' s should explain to resident or FM the medications being provided. LVN 2 stated by going over the medications with FM, staff would notice the name and medications were correct. LVN 2 stated, it is important to validate with documents and verify with the medication bubble packs (card used that packages doses of medication). LVN 2 stated, there are many opportunities to verify the medications and name of resident were correct. During an interview on 05/30/24 at 10:40 a.m., with LVN 3, LVN 3 stated, When residents are going to discharge, we print out residents ' documents and most recent medication orders. LVN 3 stated, the bubble packs have a sticker on them that shows the residents name and the name of the medication. LVN 3 stated, the sticker is placed on the MDF. LVN 3 stated there was a triple check process when discharging residents with medications. LVN 3 stated, the first check is when removing resident medications from the medication cart and comparing with the most recent MD orders. LVN 3 stated the second check is when applying the sticker from the bubble pack to the MDF and reviewing the name of resident and medication on the sticker. LVN 3 stated, the third check happens when reviewing the medication with resident and FM before discharging the resident. LVN 3 stated reviewing the medications with FM and the resident and educating them about the medication would be another way to validate the correct medications were being provided to resident. During an interview on 05/30/24 at11:00 a.m., with ADM, the ADM stated, Resident 1 ' s FM came to the facility on [DATE] and notified ADM his mother had received the wrong medications upon discharge from the facility. The ADM stated the discharged resident took the wrong medications for four days at home before FM noticed the error. ADM stated FM informed him Resident 1 seemed to be more sleepy than usual while taking the medications. The ADM stated there was a potential for serious health conditions, adverse effects, and potential for death due to the medication error. The ADM stated LVN 1 did not follow the process to provide the correct medications. During an telephone interview on 05/30/24 at 11:30 a.m. with LVN 1, LVN 1 stated she was responsible for Resident 1 ' s discharge on 05/02/24. LVN 1 stated the morning shift Licensed Nurse provided her with medications for Resident 1. LVN 1 stated, I should have immediately verified the medications with the current MD orders to make sure the right medications were being provided to [Resident 1]. LVN 1 stated she did not review the medications with FM and Resident 1 and just handed them the medications. LVN 1 stated I did not follow the proper procedure for discharging [Resident 1] home with medications. LVN 1 stated she gave Resident 2 ' s medication in error and due to her negligence, there was potential for serious harm or death. During a concurrent interview and record review on 05/30/24 at 11:50 a.m., with LVN 4 Resident 1 ' s Order Summary Report was reviewed. The OSR indicated Resident 1 was prescribed the following medications. 1. Acetaminophen 325mg (milligrams -unit of measurement) Give two tablet by mouth every 4 hours as needed for Mild Pain. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Atorvastatin Calcium Oral Tablet 20 mg, Give one tablet by mouth at bedtime for hyperlipidemia. 3. Enoxaparin Sodium Injection Solution Prefilled Syringe 40mg/0.4 milliliters (ml) Inject 0.4 ml subcutaneously (beneath the skin) one time a day for prevention of blood clots. 4. Gabapentin Oral Tablet 600 mg, Give one tablet by mouth every fours for Neuropathy (weakness, numbness and pain from nerve damage) 5. Jardiance Oral Tablet 25 mg, Give 1 tablet by mouth one time a day for TYPE 2 Diabetes Mellites 6. Metformin Oral Tablet 1000 mg, Give one tablet two times a day for TYPE 2 Diabetes Mellites 7. Hydrocodone Oral Tablet 5-325mg Give one tablet every 4 hours as needed for moderate pain (4/10-6/10) (Measurement of pain scale). During a concurrent interview and record review on 05/30/24 at 11:50 a.m., with LVN 4, Resident 1 ' s MDF was reviewed. LVN 4 stated the MDF indicated another resident [Resident 2] name and medications were on the stickers placed on the MDF for Resident 1. The following medications were listed. 1. Metoprolol Succinate ER 25 mg 2. Losartan Potassium 50 mg 3. Eliquis 2.5 mg 4. Amiodarone HCL 200 mg 5. Furosemide 20 mg 6. Famotidine 40 mg 7. Atorvastatin 40 mg 8. Hydrocodone 5/325 LVN 4 stated, there was potential for harm because the incorrect medications were provided to Resident 1. LVN 4 stated, Resident 1 could of experienced low blood pressure, unstable blood sugar, and bleeding. LVN 4 stated, the LVN did not follow the discharge process and placed Resident 1 in harm ' s way. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 06/03/24 at 1:53 p.m., with the Director of Nursing (DON). The DON stated, she was at the facility on 05/02/24. DON stated, the incident occurred during shift change between AM shift and PM shift. The DON stated, LVN 1 came to her office and asked what documents needed to be signed for discharge. The DON stated, the MDF is a document used with a list of medications that will be going home with discharging resident. The DON stated MDF has a sticker placed by staff with the resident ' s name, quantity of medication, and name of medication. The DON stated the wrong medications were sent home with Resident 1. The DON stated the medications provided were for Resident 2 (roommate) to Resident 1. The DON stated a review of the Summary Discharge Medication Error document indicates the morning nurse denies removing the medications out of the medication cart in anticipation for the discharge. The DON stated the facility is unsure which staff removed the medications from the cart. The DON stated LVN 1 did not review the medications with the FM or resident prior to discharge. The DON stated LVN 1 should have had the most active medication orders from the MD and compared it to the medications Resident 1 was handed before being discharged home. The DON stated Resident 1 discharged home with seven medications that were not prescribed to her. The DON stated Resident 1 went home with a blood thinner, diuretic (medicine used to make more urine), two high blood pressure medications and fatty acid medications. The DON stated Resident 1 did not receive her Type 2 Diabetes Medications. The DON stated Resident 1 had the potential for adverse health issues such as low blood pressure, bleeding, and unstable blood sugar. The DON stated the possibility of a serious negative outcome to Resident 1 ' s health and wellness was high due to the medication error. During a review of the facility ' s policy and procedure (P&P) titled Discharge Medications, dated 03/2022, the P&P indicated, .Unless otherwise specified by facility policy or contrary to current law or regulation, medications shall be sent with the resident upon discharge .The charge nurse shall verify that the medications are labeled consistent with current physicians orders including instructions for use .The nurse will reconcile pre-discharge medications with the president ' s post discharge medications. The medication reconciliation will be documented .The nurse shall review medication instructions with the resident, family member or representative before the resident leaves the facility .The nurse shall complete the medication disposition record including .the residents name .name of person who will be assisting or administering the medications after discharge .the name and prescription (Rx) number of each medication .the quantity or amount of each medication .the strength of each medication . During a review of the facility ' s policy and procedure (P&P) titled Staffing, Sufficient and Competent Nursing, dated August 2022, the P&P indicated, Our facility provides . nursing staff with appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment .Licensed Nurses .to provide competent resident care services including .assuring resident safety .attaining or maintaining the highest practicable physical, mental, and psychosocial well-being of each resident .Staff must demonstrate the skills and techniques necessary to care for resident needs including .Resident rights .Medication management .Communication . (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of a professional reference retrieved from https://www.ncbi.nlm.nih.gov/books/NBK560654/#:~:text=It%20is%20crucial%20that%20nurses,do%20so%20in%20clinical%20practice. titled, Nursing Rights of Medication Administration, dated 9/4/2023, the reference indicated, . Nurses have a unique role and responsibility in medication administration, in that they are frequently the final person to check to see that the medication is correctly prescribed and dispensed before administration . It is standard during nursing education to receive instruction on a guide to clinical medication administration and upholding patient safety known as the ' five rights ' . of medications administration . ' Right Patient ' . ascertaining that a patient being treated is, in fact, the correct recipient for whom medication was prescribed . this is best practiced by nurses directly asking a patient to provide his or her full name aloud . It is advisable not to address patients by first name or surname [last name] alone, in the event, there are two or more patients with identical or similar names in a unit . nurses are advised to confirm a patient ' s identity through alternative means with appropriate due dilige