STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055886	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Roseville Care Center	1161 Cirby Way Roseville, CA 95661

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 - Some	Ensure that residents are free from significant medication errors. 46995 Based on interview and record review, the facility failed to ensure residents were free from significant medication errors for one of four sampled residents (Resident 1) when Resident 1 received Isavuconazonium Sulfate Capsule (an antifungal medication- used to treat lung infections) every eight hours when the physician's order from the hopsital was to receive the medication one time per day. This failure resulted in Resident 1 receiving 32 extra doses of medication, which increased the potential for adverse systemic effects and jeopardized Resident 1's health. Resident 1 was admitted to the facility in mid-2024 with diagnoses which included allergic bronchopulmonary aspergillosis (a fungal infection of the lung), chronic obstructive pulmonary disease (lung disease that damages the airway and other parts of the lung making it difficult to breath) and chronic kidney disease (damage to the kidneys that occurs over time). During a review Resident 1's MEDICATION SUMMARY FOR PATIENT TRANSFER, dated 7/22/24, the medication summary indicated, ISAVUCONAZONIUM SULFATE CAP [capsule], ORAL 372 MG [mg = milligram, unit of measurement] PO [by mouth] .Note: Starting on 7/23, 372 mg .ONCE daily . During a review Resident 1's Order Summary Report [OSR], Active Orders As Of 7/23/24, the OSR indicated, Isavuconzonium Sulfate Oral Capsule 186 MG .Give 2 capsules orally every 8 hours for Fungal Infection . During a review of Progress Notes [PN] Type: Physician's Order Note, dated 7/22/24 at 5:40 p.m., the PN indicated, Note text: This order is outside of the recommended dose of frequency .Isavuconazonium Sulfate Capsule .the daily dose of 6 capsules exceeds theusual [sic] dose .the frequency of 3 times per day exceeds the usual frequency of every 7 days to daily . During a review of Resident 1's Medication Administration Record (MAR), dated 7/1/24-7/31/24, the MAR indicated, Isavuconzonium Sulfate Oral Capsule 186 MG .Give 2 capsules orally every 8 hours for Fungal Infection . Resident 1 received 18 more doses than ordered by the physician from 7/23-7/31/24. During a review of Resident 1's Medication Administration Record (MAR), dated 8/1/24-8/31/24, the MAR indicated, Isavuconzonium Sulfate Oral Capsule 186 MG .Give 2 capsules orally every 8 hours for Fungal Infection . Resident 1 received 14 more doses than ordered by the physician from 8/1-8/7/24. (continued on next page)

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 - Some	During a review of PN Type: Physician's Order Note, dated 8/8/24 at 12:18 p.m., the PN indicated, .this writer .investigated and found the medication [Isavuconzonium Sulfate] as to be give [sic] once per day. the [sic] order was put into the system as 2 cap Q 8 hr [hour] .the discharge summary states that the medication is to be daily starting on 7/23/24 . During a review of PN Type: Nurse's Note, dated 8/8/24 at 4:15 p.m., the PN indicated, Patient is his own RP [responsible party] and has been informed about the medication error regarding the incorrect dosing. Order has been changed and physician ordered CMP [Comprehensive Metabolic Panel, blood test to screen for a range of potential health problems] and liver function test . During a review of the manufactures insert and recommendations for Isavuconzonium Sulfate titled, HIGHLIGHTS OF PRESCRIBING INFORMATION, undated, the recommendations indicated, Recommended Dosage .in adult patients .Two 186 mg capsules [372 mg] orally once daily OVERDOSAGE: During clinical studies the total daily CRESEMBA [brand name of Isavuconzonium Sulfate] doses higher than the recommended dose regimen were associated with an increased rate of adverse reactions. At supratherapeutic doses [three times the recommended maintenance dose] .there were proportionally more treatment-emergent adverse reactions than in the therapeutic dose . During a concurrent interview and record review on 8/14/24 at 11:07 a.m. with the Assistant Director of Nursing (ADON) of Resident 1's electronic health record (EHR), the ADON confirmed the admission hospital orders indicated Isavuconazonium was to be administered once a day. The ADON confirmed the MAR indicated Isavuconazonium had been administered every eight hours. When asked if Resident 1's orders were correctly entered into the EHR, the ADON stated, No. When asked if Resident 1 received the incorrect dosage of medication from 7/23/24 until 8/8/24, the ADON stated, Yes. During an interview on 8/14/24 at 11:32 a.m. with the DON, the DON confirmed Resident 1's physician orders from the hospital for Isavuconazonium were not correctly entered or followed. The DON confirmed Resident 1 received the wrong dose of medication. When asked why it was important to give the correct dose of medication the DON stated, .you need to give the right dose to cure .make sure you are not overdosing because it can lead to adverse effects . During an interview on 8/14/24 at 11:44 a.m. with the Pharmacist (PHARM) 1, the PHARM 1 was able to access Resident 1's physician orders and confirmed the orders indicated the medication was entered into the MAR to be administered every eight hours from 7/23/24 until 8/8/24. The PHARM 1 was asked about recommended dosing for Isavuconazonium. PHARM 1 stated, The initial dose was 372 mg every eight hours for six doses and then 372 mg once daily .the dose for [Resident 1] was higher than the recommended dose. During a concurrent interview and record review on 8/14/24 at 12:25 p.m. with the ADON, the ADON was asked to review the PN Type: Physician's Note for Resident 1, dated 7/22/24 which indicated, .This order is outside of the recommended dose of frequency .Isavuconazonium Sulfate Capsule . The ADON stated the Physician Note was, .an automated system generated warning from [charting program]. When asked if there was any follow up to the note regarding the medication amount being outside the recommended dose, the ADON stated, No one acted upon it. There was no follow up. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/15/24 at 12:41 p.m. with the Physician's Assistant (PA), the PA was asked about the PN Type: Physician's Note for Resident 1 on 7/22/24. The PA stated, .as a provider we don't see those notes . During a review of the facility's policy and procedure (P&P) titled, Adverse Consequences and Medication Errors, dated 2/23, the P&P indicated, .Residents receiving medications are monitored for adverse consequences .When a resident receives a new medication order, review the following .the dose .and monitoring are in agreement with current clinical practice, clinical guidelines, and/or manufacturer's specifications for use . During a review of the facility's P&P titled, Reconciliation of Medications on Admission, dated 7/17, the P&P indicated, .The purpose of this procedure is to ensure medication safety by accurately accounting for the resident's medications, routes and dosages upon admission or readmission to the facility .Medication reconciliation helps to ensure that medications, routes and dosages have been accurately communicated to the Attending Physician and care team .If there is a discrepancy or conflict in medications, dose, route or frequency, determine the most appropriate action to resolve the discrepancy .