

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055955	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2024
NAME OF PROVIDER OR SUPPLIER California Home for the Aged		STREET ADDRESS, CITY, STATE, ZIP CODE 6720 E. Kings Canyon Fresno, CA 93727	

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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47254</p> <p>Based on interview and record review, the facility failed to ensure licensed nurses administered medications in accordance with professional standards of practice for one of three sampled residents (Resident 1), when Resident 1 received medications that were not prescribed for her on 8/20/24.</p> <p>This failure resulted in Resident 1 receiving medication not prescribed for her which had the potential to place Resident 1 at risk for adverse drug effects (an injury resulting from medical intervention related to a drug that includes medication errors).</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record (AR) (document containing resident demographic information and medical diagnosis), dated 09/4/24, the AR indicated Resident 1 was admitted to the facility on [DATE]. Resident 1's diagnosis included but are not limited to .TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS (chronic condition that affects the way the body processes blood sugar) . HYPO-OSMOLALITY AND HYPONATREMIA (having low levels of electrolytes (including sodium), proteins and nutrients) .</p> <p>During a review of Resident 1's Admission MDS assessment, dated 8/26/24, the Admission MDS assessment indicated, Resident 1's Brief Interview for Mental Status (BIMS -an evaluation of attention, orientation, and memory recall) score of 13 (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment), indicating Resident 1 had no cognitive impairment.</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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 9/4/24 at 4:00 p.m., with Licensed Vocational Nurse (LVN) 1, Resident 1's Medication Order Summary Report dated 9/4/24 was reviewed. LVN 1 stated Resident 1's Physician orders did not include pantoprazole 40 mg 1 tablet, carvedilol 6.25mg 1 tablet, potassium phosphate 500 mg 0.5 tablet, amlodipine 5 mg 1 tablet, memantine 5 mg 1 tablet, pioglitazone 30 mg 1 tablet. LVN 1 stated she failed to verify the right patient prior to administering pantoprazole 40 mg 1 tablet, carvedilol 6.25mg 1 tablet, potassium phosphate 500 mg 0.5 tablet, amlodipine 5 mg 1 tablet, memantine 5 mg 1 tablet, pioglitazone 30 mg 1 tablet. LVN 1 stated she assumed it was the right person by the picture provided in the medication administration software. LVN 1 stated she did not follow doctor's directions for medication administration and did not follow facility policies. LVN 1 stated it is the responsibility of the nurse to provide medications per the physician order and verify the correct patient during medication administration. LVN 1 stated she was taught to verify the correct patient prior to medication dosage administration but she did not follow her training and provided the medication without confirmation. LVN 1 stated it is the expectation of all nursing staff to follow doctor's orders, and to ensure the correct resident is given the correct medication. LVN 1 stated giving a resident the wrong medication can put resident at risk for adverse reactions which can include but not limited to possible death.</p> <p>During a concurrent interview and record review on 9/4/24 at 5 p.m., with the Director of Nurses (DON), Resident 1's Medication Order Summary report dated 9/4/24 was reviewed. DON validated the following medications were given to the resident in error: pantoprazole 40 mg 1 tablet, carvedilol 6.25mg 1 tablet, potassium phosphate 500 mg 0.5 tablet, amlodipine 5 mg 1 tablet, memantine 5 mg 1 tablet, pioglitazone 30 mg 1 tablet. DON stated it is the expectation of nursing staff to provide medications according to doctors' orders and according to plan of care. The DON stated LVN 1 failed to provide the correct medications for Resident 1. The DON stated LVN 1 failed to follow the facility's Administration Medications policy and procedure. The DON stated when LVN 1 administered Resident 1's medication she did not follow the five rights of medication administration the right patient, the right drug, the right time, the right dose, and the right route.</p> <p>A review of the facility policy and procedure, titled, Administering Medications, dated April 2019, indicated . Medications are administered in accordance with prescriber orders, including any required time frame . Medications errors are documented, reported and reviewed by the QAPI .if a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose .</p> <p>During a review of a professional reference The Agency for Healthcare Research and Quality (AHRQ), retrieved from https://psnet.ahrq.gov/primers/primer/23/Medication-Errors-and-Adverse-Drug-Events titled To Prevent Adverse Medication Errors, dated 9/7/2019 indicated, .Adverse drugs events are one of the most common preventable adverse events in all settings of care .ensuring safety at each stage of the pathway, namely, prescribing, transcribing, dispensing, and administration, was required .</p> <p>During a review of a professional reference titled Lippincott Manual of Nursing Practice (11th ed.), dated 2018, indicated, Legal claims most commonly made against professional nurses include the following departures from appropriate care: failure to assess the patient properly or in a timely fashion, follow physician orders, follow appropriate nursing measures, communicate information about the patient, adhere to facility policy or procedure, document appropriate information in the medical record, administer medications as ordered, and follow physician's orders that should have been questioned or not followed, such as orders containing medication dosage errors.</p>