

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056136	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/13/2024
NAME OF PROVIDER OR SUPPLIER Villa Mesa Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 867 E. 11th Street Upland, CA 91786	

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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47110</p> <p>Based on observation, interview, and record review, the facility failed to maintain an accurate record of Norco (a controlled medication that combines two types of drugs, acetaminophen and hydrocodone, for pain management) for one of five sample residents (Resident 4) when a Licensed Vocational Nurse (LVN1) administered Norco to Resident 4 and failed to document.</p> <p>This failure had the potential in delaying the recognition of possible diversion of a control medication.</p> <p>Findings:</p> <p>During a review of Resident 1 Face Sheet (contain resident demographic), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE], with a diagnosis that included Hemiparesis (one-sided muscle weakness), Dysphagia (difficulty swallowing), Hypertensive (high blood pressure) heart disease.</p> <p>A review of Resident 4's Orders, dated November 30, 2024, indicated, Norco 5-325 milligram (mg-unit dosing medication, a combination of 325 mg of acetaminophen and 5 mg of hydrocodone) was ordered to be given as needed for moderate pain (pain scale to evaluate pain level of patients).</p> <p>A review of the controlled drug log for Resident 4 indicated that Narco oral tablets, 5-325 mg, were administered on the following dates and times: December 1, 2024, at 09:10; December 2, 2024, at 01:50, 09:00, and 21:52; December 3, 2024, at 03:30 and 08:30; December 4, 2024, at 05:20; December 5, 2024, at 04:25 and 09:00; December 6, 2024, at 02:45 and 09:00; December 7, 2024, at 09:00; December 8, 2024, at 09:00; December 10, 2024, at 05:90; December 11, 2024, at 09:00; December 12, 2024, at 04:36 and 09:00; and December 13, 2024, at 05:30.</p> <p>A review of Resident 4's eMAR indicated that Narco oral tablets, 5-325 mg, were administered on the following dates and times: December 2, 2024, at 0116 hours; December 2, 2024, at 2126 hours; December 3, 2024, at 0329 hours; December 3, 2024, at 0814 hours; December 4, 2024, at 0518 hours; December 5, 2024, at 0425 hours; December 6, 2024, at 0243 hours; December 10, 2024, at 0544 hours; December 12, 2024, at 0436 hours; and December 13, 2024, at 0519 hours.</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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During concurrent telephone interview and record review on December 17, 2024 at 11:08 AM, with the Director of Nursing (DON 1), Resident 4's eMAR and controlled drug book were reviewed. The DON 1 confirmed that on the following dates and times-December 1, 2024, at 9:00 AM; December 2, 2024, at 9:00 AM; December 5, 2024, at 9:00 AM; December 6, 2024, at 9:00 AM; December 7, 2024, at 9:00 AM; December 8, 2024, at 9:00 AM; December 11, 2024, at 9:00 AM; and December 12, 2024, at 9:00 AM-medications were documented as administered in the controlled drug book but were not recorded in the eMAR. Additionally, she emphasized that LVN1 should be aware that when administering narcotics, it is essential to sign both the eMAR and the controlled drug book.</p> <p>During concurrent telephone interview and record review on December 17, 2024 at 11:26 AM with LVN 1. The eMAR and controlled drug book for Resident 4 were examined. LVN 1 confirmed that she had recorded in the control book the administration of Narco to Resident 4, but did not sign the eMAR for these administrations on the following dates and times: December 1, 2024, at 0900; December 2, 2024, at 0900; December 5, 2024, at 0900; December 6, 2024, at 0900; December 7, 2024, at 0900; December 8, 2024, at 0900; December 11, 2024, at 0900; and December 12, 2024, at 0900. LVN 1 indicated that, according to policy, it is mandatory to sign the eMAR whenever medication is administered, and both the eMAR and the Narcotic Control Book must be signed for narcotics. She emphasized that failing to sign the eMAR when administering medication is unacceptable. LVN 1 further stated the fact that she didn't sign the eMAR was a coincidence. She claimed to have signed the eMAR for other medications, but she was unable to provide an explanation for why it was a coincidence that she did not sign the eMAR for narcotics alone. She acknowledged that the signatures on the eMAR are essential for verifying that medications have been administered, while the signatures in the Narcotic Control Book are necessary to ensure accurate medication counts.</p> <p>A review of the facility Policy & Procedure (P&P) titled, Documentation of Medication Administration indicated, .1. A nurse or certified medication aide (where applicable) documents all medications administered to each resident on the resident's medication administration record (MAR). 2. Administration of medication is documented immediately after it is given .</p>		