STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056215	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northbrook Healthcare Center	64 Northbrook Way Willits, CA 95490

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 52066 Based on observation, interview, record review, and facility policy review, the facility failed to maintain a medication error rate of 5 percent (%) or less. There were 3 errors out of 43 opportunities, which resulted in a medication error rate of 6.98 % for 2 (Resident #2 and Resident #4) of 5 residents observed during medication administration. Findings included: A facility policy titled, Administration Procedures For All Medications, dated 05/2022, indicated, C. Review 5 Rights (3) times: 1) Prior to removing the medication package/container from the cart/drawer; a. Check MAR/TAR [medication administration record/treatment administration record] for order. b. Note any allergies or contraindications the resident may have prior to drug administration. c. If unfamiliar with the medication, consult a drug reference, manufacturer package insert, or pharmacist for more information. d. Check for vital signs, other tests to be done during/prior to medication administration. e. Prepare resident for medication administration. 2) Prior to removing the medication from the container a. Check the label against the order on the MAR. b. Note any supplemental labeling that applies (fractional tablet, multiple tablets, volume of liquid, shake well, give with another medication, etc. [et cetera, and other similar things]). 1. An Admission Record indicated the facility admitted Resident #2 on 10/10/2008. According to the Admission Record, the resident had a medical history that included diagnoses of heart failure, atherosclerotic heart disease, and constipation. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/05/2025, revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. Resident #2's Order Summary Report, reflecting active orders as of 04/09/2025, contained an order dated 10/30/2015 for aspirin 81 milligram (mg), give two tablets by mouth one time a day for coronary atherosclerosis. The Order Summary report also contained an order dated 05/04/2023 for sennosides-docusate sodium 8.6-50 mg, give two tablets by mouth one time a day for bowel care, with instructions to hold for loose stools. Resident #2's 04/2025 MAR revealed the resident's aspirin and sennosides-docusate sodium were scheduled for administration at 8:00 AM each day. (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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation of medication administration on 04/09/2025 at 7:05 AM, revealed Registered Nurse (RN) #3 administered one aspirin 81 mg tablet and one sennosides-docusate sodium 8.6-50 mg tablet to Resident #2, instead of two of each tablet as ordered. During an interview on 04/10/2025 at 2:28 PM, RN #3 stated he had been trained and was expected to follow physician orders. During an interview on 04/10/2025 at 4:18 PM, the Director of Nursing (DON) stated staff were trained to verify the dose and the order for the number of tablets to be administered. The DON stated staff were expected to administer medications by using the seven rights of medication administration (right patient, right medication, right dose, right route, right time, right documentation, and right response). During an interview on 04/10/2025 at 4:49 PM, the Administrator stated staff were trained and expected to administer the right medications and doses using the seven rights of medication administration. 2. An Admission Record indicated the facility admitted Resident #4 on 07/31/2023. According to the Admission Record, the resident had a medical history that included diagnoses of aftercare following joint replacement surgery and unilateral primary osteoarthritis, left hip. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/05/2025, revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Resident #4's Order Summary Report, reflecting active orders as of 04/09/2025, contained an order dated 03/21/2025 for Bengay greaseless cream 10-15%, apply topically four times a day for arthritis pain management to bilateral knees and bilateral hands. An observation of medication administration on 04/09/2025 at 7:34 AM, revealed Registered Nurse (RN) #4 applied Resident #4's Bengay greaseless cream to the resident's bilateral knees but not their bilateral hands. During an interview on 04/09/2025 at 1:23 PM, RN #4 stated she should have applied the Bengay cream to the resident's hands as well, but it was an oversight. She stated she was expected to administer medications as ordered. During an interview on 04/10/2025 at 4:18 PM, the Director of Nursing (DON) stated staff were expected to administer medications by using the seven rights of medication administration (right patient, right medication, right dose, right route, right time, right documentation, and right response). During an interview on 04/10/2025 at 4:49 PM, the Administrator stated staff were trained and expected to administer the right medications and doses using the seven rights of medication administration.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 35314 Based on interview, record review, and facility document and policy review, the facility failed to ensure medication administration records accurately reflected the medications administered for 1 (Resident #27) of 5 residents reviewed for unnecessary medications. In addition, the facility failed to ensure medication orders were correctly transcribed into the electronic health record (EHR) for 1 (Resident #2) of 5 residents observed during medication administration. Findings included: 1. A facility policy titled, Administration Procedures for All Medications dated 05/2022, revealed, J. After administration, return to the cart, replace medication container (if multi-dose and doses remain), and document administration in the MAR [Medication Administration Record] or TAR [Treatment Administration Record]. An Admission Record revealed the facility admitted Resident #27 on 01/17/2025. According to the Admission Record, the resident had a medical history that included diagnoses of gout and chronic kidney disease. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/26/2025, revealed Resident #27 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Resident #27's Order Summary Report, reflecting active orders as of 04/10/2025, contained the following orders: - an order dated 03/30/2025 for ascorbic acid 1000 milligrams (mg) by mouth twice a day for supplement; - an order dated 03/30/2025 for Eliquis 5 mg by mouth two times a day for anticoagulant; - an order dated 03/30/2025 for potassium chloride extended release 20 milliequivalents (mEq) two times a day for hypokalemia (low potassium levels); - an order dated 03/30/2025 for Senna, two tablets by mouth two times a day for routine bowel care; - an order dated 03/24/2025 for ciclopirox external gel 0.77 percent (%), apply to bilateral toenails topically at bedtime for yellow, brittle, thickened, fungal toenails; and - an order dated 03/09/2025 for nystatin cream 100000 units per gram, apply to groin/ pannus topically every shift for redness. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #27's 04/2025 TAR revealed no documentation of the administration of the resident's ciclopirox external gel on 04/02/2025 and 04/03/2025 at 8:00 PM or the resident's nystatin cream on 04/02/2025 or 04/03/2025 for the NOC 1 (evening) doses. Resident #27's 04/2025 MAR revealed no documentation of the administration of the resident's ascorbic acid, Eliquis, potassium chloride extended release, or Senna tablets on 04/05/2025 at 4:00 PM. During an interview on 04/09/2025 at 1:41 PM, Resident #27 stated they had not missed any doses of their medications while at the facility. Resident #27 stated that on 04/02/2025 and 04/03/2025, they received their medications and treatments as ordered. Resident #27 further stated that on 04/05/2025, they left the facility for a memorial service but received their medication after returning to the nursing facility the same day. During an on 04/10/2025 at 12:46 PM, the Director of Nursing (DON) stated Licensed Vocational Nurse (LVN) #1 was the nurse assigned to Resident #27 on 04/02/2025 and 04/03/2025. The DON stated she expected nurses to document the administration of medications or treatments on the MAR or TAR. During an interview on 04/10/2025 at 3:44 PM, LVN #1 stated he struggled to sign off on the MAR because he would get busy and forget to sign off that the medication was administered. He stated Resident #27 had received all their medications, but he had not documented it on the MAR. During an interview on 04/10/2025 at 2:32 PM, LVN #2 stated he was the nurse assigned to Resident #27 on 04/05/2025. LVN #2 stated the resident went to a memorial service and returned to the facility the same day. LVN #2 stated he administered the resident's medications when they returned to the facility but did not document the administration on the resident's MAR. During an interview on 04/10/2025 at 2:19 PM, the Administrator stated nurses should document on the MAR when medications were administered. 52066 2. An Admission Record revealed the facility admitted Resident #2 on 10/10/2008. According to the Admission Record, the resident had a medical history that included a diagnosis of heart failure. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/05/2025, revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. A handwritten physician's order for Resident #2, dated 03/23/2025, specified an order for Bumex (a diuretic medication) 0.5 milligrams (mg) in the morning and 0.25 mg at 1:00 PM, with instructions to hold the Bumex for a systolic blood pressure reading less than (<) 110 millimeters of mercury (mmHg). Resident #2's Order Summary Report, reflecting active orders as of 04/09/2025, revealed the order for Bumex was transcribed into the EHR as two separate orders. The orders, dated 03/24/2025, specified Bumex 0.25 mg was to be given once a day and held for a systolic blood pressure < 110 mmHg; however, the order for Bumex 0.5 mg once a day was transcribed with instructions to hold for a systolic blood pressure greater than (>) 110 mmHg. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Orders note, effective 03/24/2025, revealed Licensed Vocational Nurse (LVN) #2 transcribed Resident #2's Bumex orders into the resident's EHR. During an interview on 04/10/2025 at 2:33 PM, LVN #2 stated that when he received a new order, he read it and entered it into the EHR. LVN #2 stated that Resident #2's order with parameters to hold the medication for a systolic blood pressure > 110 mmHg was a mistake. LVN #2 stated he had received education regarding transcribing physician's orders, and he was expected to transcribe physician's orders correctly. During an interview on 04/09/2025 at 4:36 PM, the Medical Director stated the staff were to hold Resident #2's Bumex if the resident's systolic blood pressure was < 110 mmHg. The Medical Director stated she thought the order was a typo, and the nursing staff should know not to hold the Bumex for a systolic blood pressure > 110 mmHg, as that would never be appropriate. During an interview on 04/10/2025 at 2:19 PM, the Administrator stated staff were trained and expected to transcribe physician's orders correctly.