STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056238	A. Building B. Wing	02/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Vallejo Nursing & Rehabilitation Center	2200 Tuolumne Street Vallejo, CA 94589

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 49933 Based on observation, interview, and record review, the facility failed to provide quality of care and treatment for one of four sampled residents (Resident 1) when Resident 1 was not informed of medication changes and didn't receive her diuretic (treatment for edema and swelling) medication per assessment, plan of care and physician's order. This failure had the potential to result in a negative outcome. Findings: Resident 1 was admitted to the facility May 2012 with multiple diagnoses which included congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). Resident 1's Minimum Data Sheet (MDS - a federally mandated resident assessment tool), dated 1/12/25, indicated Resident 1 had intact cognition. The MDS also indicated Resident 1 was receiving a diuretic, a high-risk drug medication. During a concurrent observation and interview on 2/18/25, at 11:42 a.m., Resident 1 was sitting in her wheelchair receiving oxygen. Resident 1 stated, I was not informed about my [brand name] [diuretic medication] being increased to 80 mg (milligram-unit of measure) and changed for 3 days and now I didn't get my [brand name] [diuretic medication] for a couple days .I have been short of breath and wheezing since this morning. Resident 1 further stated she has been on this diuretic medication long term and has been getting anxiety over sudden medication changes and pressure to verify that the correct medication and dosages were being given to her by the nurses. During a review of Resident 1's Care Plan (CP), dated 3/16/21, indicated, Resident will not experience any signs/symptoms of fluid overload (too much fluid in the body) as evidenced by the absence of . edema and dyspnea (shortness of breath or difficulty breathing). Resident 1 ' s CP's interventions included .medication as ordered. During a review of Resident 1's Medication Administration Record (MAR- a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 2/1/25 to 2/28/25, indicated Furosemide Oral Tablet 40 MG .Give 1 tablet by mouth two times a day . The MAR indicated Resident 1 received the 40 mg dose from 2/1/25-2/11/25. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s MAR, indicated Resident 1 ' s diuretic medication dose was increased to 80 mg on 2/11/25 to 2/14/25 with the order which indicated, Furosemide Oral Tablet 40 MG .Give 2 tablet by mouth two times a day .for 3 Days. During a review of Resident 1 ' s MAR, the MAR further indicated that no medication (Furosemide) was administered, and Resident 1 didn't receive her medication (Furosemide) on 2/14/25 at 4p.m. to 2/18/25 as evidenced by no Licensed Nurse initials. During a review of Resident 1 ' s progress notes from 2/1/25 to 2/18/25, indicated, there was no documented evidence of nursing assessment, justification of medication changes and notification to Resident 1 regarding changes of her diuretic medication. During a concurrent observation and interview on 2/18/25 at 12:55 p.m. with Nurse Practitioner (NP), the NP entered Resident 1 ' s room and evaluated Resident 1. NP discussed Resident 1 ' s leg swelling, wheezing and diuretic order. NP confirmed that the 40 mg dose should have been resumed last week after the 80 mg dose was completed. NP acknowledged that Resident 1 missed doses from 2/14/25 to 2/18/25. During a concurrent interview and record review on 2/18/25, at 3:15 p.m., the MAR was reviewed with Licensed Nurse (LN) 1 and confirmed Resident 1 did not receive her diuretic medication from 2/14/25 to 2/18/25. LN 1 acknowledged that she received the new order for the increase dose of Resident 1 ' s diuretic medication. LN 1 confirmed there was no documented evidence of nursing notes and assessment. LN 1 further confirmed that there was no documented evidence that Resident 1 was notified of medication changes. During an interview on 2/18/25, at 4:00 p.m., when asked what the expectations for the LNs regarding receiving physician orders and nursing documentation were, the Director of Nursing (DON) stated that LNs are supposed to make sure the order is correct and administered and follow up with a progress note and notify the resident for any medication changes. DON further stated that any change of condition should be assessed by the LNs and documented. During a review of the facility's policy and procedure (P&P) titled, Physician Orders dated 3/22/22, indicated, Licensed Nurse receiving the order will be responsible for documenting and implementing the order . During a review of the facility's P&P titled, Guidelines for charting and documentation, dated 2001, indicated, Chart all pertinent changes in the resident's condition, reaction to treatments, medication, etc . Documentation should also include: Any time the physician or family is called about the resident and their response; Each time a physician visits the resident; Whenever the level of care changes . During a review of the facility's P&P titled, Change of Condition: Notification of, dated 8/25/2021, indicated A Facility must immediately inform the resident, consult with the Resident's physician and/or NP . when: A need to alter treatment significantly (that is, a need to discontinue or change an existing form of treatment .