STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056361	A. Building B. Wing	02/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fortuna Rehabilitation and Wellness Center, LP	2321 Newburg Road Fortuna, CA 95540

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 - Few	Ensure that residents are free from significant medication errors. 41283 Based on interviews and record reviews, the facility failed to ensure that one of three sampled residents, Resident 1, was free from a significant medication error when an extra dose of Oxycodone (Oxycodone belongs to a class of drugs known as opioid analgesics. It works in the brain to change how your body feels and responds to pain) HCL (Hydrochloride) 5 mg (milligrams) was administered by Licensed Nurse A without a physician's order. This failure had the potential to result in an adverse (having a negative or harmful effect on something) reaction to Resident 1 that could affect his health and safety. Findings: A review of Resident 1's Order Summary Report, dated 2/15/24, indicated he had an order for Oxycodone HCL 5 mg, give 1 tablet by mouth every 6 hours as needed for pain, only use when non-narcotic options are ineffective. A review of Resident 1's MAR (Medication Administration Record) indicated on 2/11/24, he was given Oxycodone HCL 5 mg at 6:30 a.m. and 10 a.m. The MAR indicated that the dose given at 10 a.m. was for a one-time dose only ordered on 2/11/24. A review of Resident 1's Individual Narcotic Record, for Oxycodone HCL 5 mg indicated, on 2/11/24, Licensed Nurse B signed off on one tablet at 6:30 a.m., and Licensed Nurse A signed off on one tablet at 9:15 a.m. During an interview on 2/15/24, at 3:45 p.m., with Licensed Nurse A, she stated an on-call physician, Physician C, called her back on 2/11/24, at around 9:05 a.m. to 9:10 a.m. with the order so she administered the Oxycodone HCL 5 mg to Resident 1 because he was in excruciating (unbearably painful) pain. During an interview on 4/12/24, at 11;30 a.m., with the Director of Nursing (DON), she stated that the administration of the Oxycodone HCL 5 mg by Licensed Nurse A was a medication error because Physician C could not recall giving the order to Licensed Nurse A for the extra dose of Oxycodone HCL 5 mg. The DON stated that Licensed Nurse A was terminated because of this incident. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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 - Few	A review of Resident 1's Progress Notes, dated 3/1/24, at 11:03 a.m., authored by the DON indictaed, On 2/11/24, resident (Resident 1) recived an unscheduled dose of oxycodone 5 mg .the administration of the dose of oxycodone documented in the record as one-time dose on 2/11/24, is determined to be a medication error. During an interview on 4/12/24, at 11:52 a.m., with Physician D (Resident 1's attending Physician and the Medical Director of the facility), she stated that she did an investigation and found out that Licensed Nurse A administered an extra dose of Oxycodone HCl 5 mg to Resident 1 without a physician's order from her or from Physician C. Physician D stated that the medication error did not result in physical harm to Resident 1. Physician D stated that Licensed Nurse A was terminated after the investigation had concluded. A review of a facility policy and procedure (P&P) titled, Medication Administration, dated January 1, 2012, the purpose of the policy indicated, To ensure the accurate administration of medications for residents in the facility. Under Policy the P&P indicated, Medication will be administered directed by a Licensed Nurse upon the order of a physician or licensed independent practitioner. Based on interviews and record reviews, the facility failed to ensure that one of three sampled residents, Resident 1, was free from a significant medication error when an extra dose of Oxycodone (Oxycodone belongs to a class of drugs known as opioid analgesics. It works in the brain to change how your body feels and responds to pain) HCL (Hydrochloride) 5 mg (milligrams) was administered by Licensed Nurse A without a physician's order. This failure had the potential to result in an adverse (having a negative or harmful effect on something) reaction to Resident 1 that could affect his health and safety. Findings: A review of Resident 1's Order Summary Report, dated 2/15/24, indicated he had an order for Oxycodone HCL 5 mg, give 1 tablet by mouth every 6 hours as needed for pain, only use when non-narcotic options are ineffective. A review of Resident 1's MAR (Medication Administration Record) indicated on 2/11/24, he was given Oxycodone HCL 5 mg at 6:30 a.m. and 10 a.m. The MAR indicated that the dose given at 10 a.m. was for a one-time dose only ordered on 2/11/24. A review of Resident 1's Individual Narcotic Record, for Oxycodone HCL 5 mg indicated, on 2/11/24, Licensed Nurse B signed off on one tablet at 6:30 a.m., and Licensed Nurse A signed off on one tablet at 9:15 a.m. During an interview on 2/15/24, at 3:45 p.m., with Licensed Nurse A, she stated an on-call physician, Physician C, called her back on 2/11/24, at around 9:05 a.m. to 9:10 a.m. with the order so she administered the Oxycodone HCL 5 mg to Resident 1 because he was in excruciating (unbearably painful) pain. During an interview on 4/12/24, at 11;30 a.m., with the Director of Nursing (DON), she stated that the administration of the Oxycodone HCL 5 mg by Licensed Nurse A was a medication error because Physician C stated she could not recall giving the order to Licensed Nurse A for the extra dose of Oxycodone HCL 5 mg. The DON stated that Licensed Nurse A was terminated because of this incident. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1's Progress Notes, dated 3/1/24, at 11:03 a.m., authored by the DON indicated, On 2/11/24, resident (Resident 1) received an unscheduled dose of oxycodone 5 mg .the administration of the dose of oxycodone documented in the record as one-time dose on 2/11/24, is determined to be a medication error. During an interview on 4/12/24, at 11:52 a.m., with Physician D (Resident 1's attending Physician and the Medical Director of the facility), she stated that she did an investigation and found out that Licensed Nurse A administered an extra dose of Oxycodone HCl 5 mg to Resident 1 without a physician's order from her or from Physician C. Physician D stated that the medication error did not result in physical harm to Resident 1. Physician D stated that Licensed Nurse A was terminated after the investigation had concluded. A review of a facility policy and procedure (P&P) titled, Medication Administration, dated January 1, 2012, the purpose of the policy indicated, To ensure the accurate administration of medications for residents in the facility. Under Policy the P&P indicated, Medication will be administered directed by a Licensed Nurse upon the order of a physician or licensed independent practitioner.