STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056399	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Casa via Transitional Care Center	1449 Ygnacio Valley Road Walnut Creek, CA 94598

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. Based on observation, interview, and record review, the facility failed to ensure one of five sampled residents (Resident 181) was monitored for side effects of divalproex sodium (Depakote -a mood stabilizing medication) which was given to Resident 181 in error. This failure exposed Resident 181 to potentially serious adverse effects. Findings: During a review of Resident 181's admission Record, printed on 6/3/25, the admission Record indicated Resident 181 was admitted to the facility in March 2025. During a review of Resident 181's Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan), dated 3/28/25, indicated Resident 181 had a Brief Interview of Mental Status (BIMS, a scoring system used to determine the resident's cognitive status in regard to attention, orientation, and ability to register and recall information) score of 12 out of 15 indicating moderate cognitive impairment. The MDS also indicated, Resident 181 had multiple diagnoses that included, hip fracture and depression. The MDS revealed Resident 181 did not have symptoms of mood disturbances and/or physical and verbal symptoms directed to self or others. During an interview on 6/2/25 at 12:25 p.m. with Facility Medical Practitioner (FMP), FMP stated, divalproex sodium was indicated for residents with behavioral disturbances. FMP also stated, Residents receiving divalproex sodium should be monitored for sedation/hyperactivity as well as monitored for effectiveness and for side effects especially in the elderly. FMP added Resident 181 received divalproex sodium in error but should have been monitored regardless. During an interview on 6/3/25 at 2:43 p.m., with the Director Of Nursing (DON), DON acknowledged Resident 181 was administered divalproex sodium in error. DON added, it was important to have behavioral and side effects monitoring on Residents receiving psychotropic medication to ensure effectiveness and monitor for side effects. DON confirmed, there was no monitoring for Resident 181's divalproex sodium use. During a telephone interview on 6/4/25, at 2:05 p.m., with the Facility Pharmacy Consultant (FPC), FPC stated, she wrote a report to the prescribing physician with recommendation to clarify Resident 181's diagnosis. FPC added, the physician's order for divalproex sodium did not include behavioral and side effects monitoring. (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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(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	During a review of Resident 181's Order Summary Report, dated 6/4/25, the Order Summary Report indicated a physician order for Divalproex Sodium Oral Tablet Delayed Release 125 MG (Divalproex Sodium) Give 1 tablet by mouth two times a day for mood instability with start date 4/8/25. During a review of Resident 181's Medication Administration Record (MAR) for April 2025, the MAR revealed, Resident 181 was administered divalproex sodium 125mg from 4/8/25 until 4/23/25. There was no documented evidence the facility had monitored for the side effects of divalproex sodium on the MAR. During a review of a document titled, Consultant Pharmacist's Medication Regiment Review (MRR), dated 4/25/25, the MRR indicated for Resident 181, Please consider adding monitoring related to side effects and targeted behavior of Depakote . During a review of the facility's policy and procedures (P&P) titled, Adverse Consequences and Medication Errors, undated, the P&P indicated .8. Facility staff monitor the resident for possible medication-related adverse consequences, including mental status and level of consciousness, when the following conditions occur: f. medication error . During a review of the facility's P&P titled, Psychotherapeutic Drug Management, dated 3/2010, the P&P indicated, This facility shall monitor all psychotherapeutic medications for effectiveness and side effects according to OBRA (Omnibus Budget Reconciliation Act - established federal standards for nursing home care in the United States) guidelines.

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. Based on interview and record review, the facility failed to ensure that one of five sampled residents (Resident 181) was not given unnecessary psychoactive (controls mood and behavior) medication when Resident 181 was given divalproex sodium (Depakote, a mood stabilizer) without appropriate indications for use. This failure resulted in Resident 181 receiving psychoactive medication without actual psychiatric diagnoses and unnecessarily exposed her to serious adverse side effects. Findings: During a review of Resident 181's admission Record, printed on 6/3/25, the admission Record indicated Resident 181 was admitted to the facility in March 2025. During a review of Resident 181's Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan), dated 3/28/25, indicated Resident 181 had a Brief Interview of Mental Status (BIMS, a scoring system used to determine the resident's cognitive status in regard to attention, orientation, and ability to register and recall information) score of 12 out of 15 indicating moderate cognitive impairment. The MDS also indicated Resident 181 had multiple diagnoses that included, hip fracture and depression. The MDS revealed Resident 181 did not have symptoms of mood disturbances and/or physical and verbal symptoms directed to self or others. During an interview on 6/3/25, at 1:41 p.m., with Registered Nurse (RN) 1, RN 1 stated she made a mistake and transcribed verbal medication order of divalproex sodium in Resident 181's medical record that was intended for Resident 52. RN 1 also stated, she did not read the order back to the ordering physician to ensure the divalproex sodium was for the right resident. During a concurrent interview and review on 6/3/25 at 2:23 p.m., the facility's policy and procedures (P&P) titled Verbal Orders, dated 2/14, was reviewed with the Director of Nursing (DON). The P&P indicated under policy interpretation and implementation .4. The individual receiving the verbal order will: a. read the order back to the practitioner to ensure that the information is clearly understood and correctly transcribed. DON stated RN 1 did not read the order back to the doctor to ensure the medication order was for Resident 181. During an interview on 6/3/25 at 2:43 p.m. with DON, DON acknowledged Resident 181 was administered divalproex sodium unnecessarily for two weeks while admitted to the facility. DON also added RN 1 made a mistake and transcribed the divalproex sodium order in Resident 181's medical record instead of Resident 52. DON also stated, Resident 181 or Responsible Party (RP) did not sign a consent for psychotropic medication. During a telephone interview on 6/4/25, at 2:05 p.m., with the Facility Pharmacy Consultant (FPC), FPC stated she wrote a report to the prescribing physician with recommendations to clarify Resident 181's diagnosis. FPC added the physician's order for divalproex sodium indicated it was for mood instability. FPC further added mood instability was not a diagnosis and was not appropriate indication for use of psychotropic medication. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 181's Order Summary Report, dated 6/4/25, the Order Summary Report indicated a physician order for Depakote Oral Tablet Delayed Release 125 MG (Divalproex Sodium) Give 1 tablet by mouth two times a day for mood instability with start date 4/8/25. During a review of Resident 181's Medication Administration Record (MAR) for April 2025, the MAR revealed Resident 181 was administered divalproex sodium 125mg from 4/8/25 until 4/23/25. During a review of document titled Note To Attending Physician/Prescriber, dated 4/8/25, the note revealed a recommendation from FPC which indicated please clarify diagnosis more specific than 'mood instability' for divalproex sodium order. During a review of Resident 181's Physician Note, dated 4/23/25, the Physician Note indicated under description: Due to a communication error between, a verbal order for divalproex sodium intended for another resident was mistakenly entered under this resident's chart. During a review of the facility's P&P titled, Psychotherapeutic Drug Management, dated 3/2010, the P&P indicated under Procedure A. .2. Informed consent shall be obtained from the resident and/or responsible party prior to the administration of psychotherapeutic medication and for each increase in dosage. 3. The psychotherapeutic medication order shall include the following information: Diagnosis for the medication. Behavior manifestations of the disorder treated i.e. auditory hallucinations, hitting others, refusing to eat etc. During a review of the facility's P&P titled, Adverse Consequences and Medication Errors, undated, the P&P indicated under policy interpretation and implementation .4. The staff and practitioner shall strive to minimize adverse consequences by: a. Following relevant clinical guidelines and manufacturer's specifications for use, dose, administration, duration, and monitoring of the medication; b. Defining appropriate indications for use; . 5. A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles for the professional(s) providing services. 6. Examples of medication errors include: .b. Unauthorized drug - a drug that is administered without a physician's order. According to the National Library of Medicine, last updated on September 4, 2023, the nurses have a unique role and responsibility in medication administration. Furthermore, it is standard during nursing education to receive instruction on a guide to clinical medication administration and upholding patient safety known as the 'five rights' or 'five R's' of medication administration which included, 'Right patient' - ascertaining that a patient being treated is, in fact, the correct recipient for whom medication was prescribed. https://www.ncbi.nlm.nih.gov/

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interview and record review, the facility failed to ensure one of five sampled residents (Resident 181) was free from significant medication error when Resident 181 was administered divalproex sodium (Depakote, a psychoactive medication that controls mood and behavior) in error 30 times. This failure resulted in Resident 181 to receive psychoactive medication in error. This failure also exposed Resident 181 to serious health complications and/or jeopardized her safety. Findings: During a review of Resident 181's admission Record, printed on 6/3/25, the admission Record indicated Resident 181 was admitted to the facility in March 2025. During a review of Resident 181's Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan), dated 3/28/25, indicated Resident 181 had a Brief Interview of Mental Status (BIMS, a scoring system used to determine the resident's cognitive status in regard to attention, orientation, and ability to register and recall information) score of 12 out of 15 indicating moderate cognitive impairment. The MDS also indicated Resident 181 had multiple diagnoses that included, hip fracture and depression. The MDS revealed Resident 181 did not have symptoms of mood disturbances and/or physical and verbal symptoms directed to self or others. During an interview on 6/3/25, at 1:41 p.m., with Registered Nurse (RN) 1, RN 1 stated she made a mistake and transcribed a verbal medication order of divalproex sodium (medication used as a mood stabilizer) in Resident 181's medical record that was intended for Resident 52. RN 1 added this resulted in Resident 181 to receive divalproex sodium in error. During an interview on 6/3/25 at 2:43 p.m., with the Director Of Nursing (DON), DON acknowledged Resident 181 was administered divalproex sodium unnecessarily for two weeks while admitted to the facility. DON also added RN 1 transcribed the medication order in error which resulted in administration of divalproex sodium to Resident 181. During a review of Resident 181's Order Summary Report, dated 6/4/25, the Order Summary Report indicated a physician order for Divalproex Sodium Oral Tablet Delayed Release 125 MG (Divalproex Sodium) Give 1 tablet by mouth two times a day for mood instability with start date 4/8/25. During a review of Resident 181's Medication Administration Record (MAR) for April 2025, the MAR revealed Resident 181 was administered divalproex sodium 125mg once on 4/8/25, twice a day from 4/9/25 thru 4/22/25, and then once on 4/23/25. During a review of Resident 181's Physician Note, dated 4/23/25, the Physician Note indicated under description: Due to a communication error between, a verbal order for Depakote intended for another resident was mistakenly entered under this resident's chart. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Adverse Consequences and Medication Errors, undated, the P&P indicated under policy interpretation and implementation .4. The staff and practitioner shall strive to minimize adverse consequences by: a. Following relevant clinical guidelines and manufacturer's specifications for use, dose, administration, duration, and monitoring of the medication; b. Defining appropriate indications for use; . 5. A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles for the professional(s) providing services. 6. Examples of medication errors include: .b. Unauthorized drug - a drug that is administered without a physician's order. According to the National Library of Medicine, last updated on September 4, 2023, the nurses have unique role and responsibility in medication administration. Furthermore, it is standard during nursing education to receive instruction on a guide to clinical medication administration and upholding patient safety known as the 'five rights' or 'five R's' of medication administration which included, 'Right patient' - ascertaining that a patient being treated is, in fact, the correct recipient for whom medication was prescribed. https://www.ncbi.nlm.nih.gov/