STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056411	A. Building B. Wing	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park View Post Acute	3751 Montgomery Dr Santa Rosa, CA 95405

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 - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents were free of medication errors when one of three sampled residents (Resident 3) was not given the correct dosage of a medication, Uptravi (generic name selexipag) a medication used to treat pulmonary hypertension (high blood pressure in the arteries that carry blood from the heart to the lungs). This failure had the potential for Resident 3 to have a drug overdose causing physical problems ranging from pain, rashes, weakness, organ failure, (when organs in the body such as the heart, lungs, kidneys or liver are unable to perform their critical functions), seizures or even death. Findings: During an interview on [DATE] at 11:55 a.m., Family member of Resident 3 (Family) complained that Resident 3 was given the wrong dose of her medication several times. Family stated they gave the facility a month supply of her medication from home because the medication was not available at all pharmacies. Family stated, I found out that my wife had been getting 4 pills per dose when it should have been 1 pill per dose when the nurse asked for a refill. Family complained We should not be out of the medication, how did it run out, can ' t the nurses read the label! Family stated they were giving her one tablet of Uptravi 800 mcg (microgram, one millionth of a gram) 2 times a day at home. During a record review on [DATE] Resident 3 ' s admission Record (form to show key facts about resident) indicated Resident 3 was admitted on [DATE] and had Diagnosis of End Stage Kidney disease, Diabetes, and Pulmonary Hypertension (HTN.) During a record review on [DATE] Resident 3 ' s Order Summary Report (Doctors orders) the medications for Resident 3 were documented. The order for Uptravi read: Uptravi oral tablet 200 mcg (Selexipag) give 4 tablets by mouth two times a day for Pulmonary HTN (800 mcg). This medication is filled by an outside specialty pharmacy. Start date [DATE]. Four tablets of 200 mcg would equal 800 mcg, which is the desired dosage. During a record review on [DATE] Resident 3 ' s Medication Administration Record (MAR) for [DATE] included Uptravi oral tablet 200 mcg (Selexipag) give 4 tablets by mouth two times a day for Pulmonary HTN (800 mcg). This medication is filled by an outside specialty pharmacy. Start date [DATE]. Nursing had administrated the medication 29 times over 15 days based on the initialing on the MAR indicating a dose was given. The MAR did not have any documentation to indicate that a nurse gave one 800mcg tablet in place of the four 200mcg tablets to be given per the doctor ' s order. (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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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and concurrent observation on [DATE] at 12:25 p.m., Licensed Staff A opened the medication cart to look at the medication bottle. The medication bottle was no longer in the medication cart. Licensed Staff A stated the bottle may have been given to the family because we needed a refill. Licensed Staff A stated she was aware that the medication bottle label indicated that the tablets were 800 mcg, and directions were for one tablet 2 times a day. Licensed Staff A stated, I was giving her 1 tablet per dose not 4 tablets. Licensed Staff A stated, I would tell the next nurse on duty to only give one tablet from the medication bottle to get the correct dose. Licensed Staff A stated the pharmacy label did not get updated to reflect the order on the MAR. During an interview on [DATE] at 1:05 p.m., Director of Nursing (DON) stated she recently learned that Resident 3 ' s medication stock was depleted before expected, and that the label did not reflect the order. DON stated the nurse last evening ([DATE]) requested help to refill Resident 3 ' s prescription for Uptravi. DON stated she was in the process of clarifying the order and needed to investigate how the month ' s supply was finished although the resident had only been at the facility for 2 weeks. During an interview on [DATE] at 1:50 p.m., Licensed Staff B stated, the day shift nurse told me we were almost out of the Uptravi and had asked the family to bring in more of the medication. Licensed Staff B stated I poured her medication and tossed the medication bottle. I administered the medications and asked the Family to bring in more of the medication. Licensed Staff B stated the family voiced concerns that the facility had gone through Resident 3 ' s medication too fast. Licensed Staff B stated she informed the DON that they needed to refill the prescription. Licensed Staff B stated, I did give her the medications on [DATE] in the evening. I read the MAR and poured out 4 pills. I do not know what the label said because I did not read it completely, I only read the MAR. During a review of the facility's policies, The policy titled Medications Brought to the Facility by Physicians or Resident Family Members, dated 5/2022, instructed medications brought to the facility by other than the designated pharmacist or agent can be accepted only if there is current order for use, the medication container is properly labeled, in a proper container, has not expired and has been positively identify by the physician or Pharmacist prior to use. The facility will have documentation that the identification has been made.'