| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265396 | A. Building<br>B. Wing | 05/03/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| California Care Center | 1106 South Oak<br>California, MO 65018 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0580<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>43024<br><br>Based on interview and record review, facility staff failed to notify one resident's (Resident #1's) out of one sampled residents' physician when the resident was given another residents medication which resulted in a hospital stay. The facility census was 29.<br><br>1. Review of the facility Medications, Errors and Drug Reactions policy, undated, showed the facility shall report all medication errors and adverse drug reactions immediately to the attending physician, Director of Nursing (DON), and the Administrator.<br><br>2. Review of Resident #1's significant change Minimum Data Set (MDS), a federally mandated assessment tool, dated 02/15/24, showed staff assessed the resident:<br><br>-Cognitively intact;<br><br>-Active diagnoses of Cancer (abnormal cell growth with the potential to invade or spread to other parts of the body) and renal failure.<br><br>Review of the resident's plan of care, undated, showed staff documented to administer medications as ordered by the physician.<br><br>Review of the residents progress notes, dated 4/17/24, showed Registered Nurse (RN) C documented, around 8:00 A.M., this nurse discovered Resident #1 was given medications that belonged to another resident at breakfast. Assessment done, no changes in condition or behavior observed. Resident played bingo where weekend manager observed the resident to be off but finished playing the game. While seated at his/her table, this nurse observed resident to be lethargic, but able to respond when talked to, vital signs were rechecked, resident hypotensive and bradycardic. Emergency Medical Services (EMS) and Director of Nursing (DON) called; resident sent to the emergency room around 11:45 A.M., later admitted to the hospital. Physician notified at 11:50 A.M.<br><br>During an interview on 5/3/24 at 9:30 A.M., the administrator said he/she expects the physician to be notified immediately if there is a medication error. He/She said the physician was not contacted until the resident had an adverse reaction and was sent to the hospital. He/She said the RN C did not contact the physician immediately because he/she wanted to stay with the resident for monitoring.<br><br>(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 0580<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During an interview on 5/3/24 at 9:51 A.M., Certififed Medication Technician (CMT) A said he/she did not contact the physician and was not asked to contact the physician by anyone else. He/She said the resident was monitored for an hour by RN C and then went to bingo where the weekend manager noticed the resident was off and that is when RN C called emergency medical services and the physician.<br><br>During an interview on 5/3/24 at 10:03 A.M., RN C said he/she realized he/she gave the wrong medication to resident #1 and monitored him/her for about an hour. He/She said he/she checked vital signs. He/She said the resident went to play bingo and when he/she checked on him/her again the weekend manager said he/she seemed off. RN C checked his/her vitals again and the resident was hypotensive and voiced he/she felt sleepy. He/She said he/she texted the physician after the resident was sent with EMS. He/She said he/she should have called the physician right away but was with the resident.<br><br>During an interview on 5/3/24 at 10:15 A.M., the DON said he/she expects staff to contact the physician immediately with medication errors.<br><br>During an interview on 5/14/24 at 1:26 P.M., the physician said he/she expects to be contacted as soon as a mistake with medications are made. He/She said he/she does not know why the facility waited to contact him/her until the resident had a negative reaction.<br><br>MO00235395 |

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| F 0760<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>43024<br><br>Based on interview and record review, facility staff failed to ensure residents remained free of significant medication errors when staff administered Resident #2's medication to Resident #1 which resulted in Resident #1 being transported to the hospital after an adverse reaction. The facility census was 29.<br><br>1. Review of the facility Medications, Administration guidelines, undated, showed it is the purpose of this facility residents receive their medicationson timely and in accordance with established policies. Drug administration shall be defined as an act in which an authorized person, in accordance with all laws and regulations governing such acts, gives a single dose of a prescribed drug or biological to a resident. The complete act of administration entails removing an individual dose from a previously dispensed, properly labeled container, verifying it with the physicians orders, giving the individual dose to the proper resident, and promptly recording the information. Staff are directed further as follows:<br><br>-The same person preparing the doses for administration must administer medications;<br><br>-The person administering the drugs must chart medications immediately following the administrations. The date, time administered, dosage, etc. must be entered in the medical record and signed by the person entering the data;<br><br>-If there is doubt as to the correct identification of a resident, medication may not be administered to that resident until positive identification has been made.<br><br>Review of the medication administration policy, undated, showed staff are directed to remain in the room while the resident takes the medication.<br><br>2. Review of Resident #1's significant change Minimum Data Set (MDS), a federally mandated assessment tool, dated 02/15/24, showed staff assessed the resident:<br><br>-Cognitively intact;<br><br>-Diagnoses of cancer (abnormal cell growth with the potential to invade or spread to other parts of the body) and renal failure.<br><br>Review of the resident's plan of care, undated, showed staff are directed to administer medications as ordered by the physician.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of the resident's progress notes, dated 4/17/24 at 6:00 P.M., showed Registered Nurse (RN) C documented, around 8:00 A.M., discovered Resident #1 given medications which belonged to another resident at breakfast. Review showed staff documented they assessed the resident, no changes in condition or behavior observed. RN C documented the resident respirations even and unlabored, lung sound clear, heart sounds regular, bowel sounds present in all quadrants, skin warm per usual. Staff documented the resident played bingo where weekend manager observed the resident to be off but finished playing the game. RN C documented he/she oserved the resident to be lethargic, but able to respond when talked to, vital signs were rechecked, resident hypotensive and bradycardic. Emergency Medical Services (EMS) and Director of Nursing (DON) called. RN C documented resident sent to the emergency room around 11:45 A.M. , later admitted to the hospital. Physician notified at 11:50 A.M.<br><br>Review of Resident #2's physician orders sheet (POS), dated 4/1/24 - 5/1/24 showed physician orders to adminsiter 6:00 A.M. to 10:00 A.M., medication pass:<br><br>-Glimepiride (high blood sugar levels cause by type 2 diabetes) 2 milligrams (mg) one time daily;<br><br>-Doxazosin (treat high blood pressure) 8 mg one time daily;<br><br>-Eliquis (an anticoagulant used to prevent blood clots and strokes) 5 mg twice daily;<br><br>-Hydralazine (treat high blood pressure) 25 mg three times daily;<br><br>-Lisinopril (treat high blood pressure) 40 mg one time daily;<br><br>-Metoprolol (treat high blood pressure) 50 mg one time daily;<br><br>-Furosemide (treat fluid retention) 40 mg one time daily.<br><br>Review of the resident's hospital records, dated 4/27/24, showed Resident #1 admitted the hospital after Skilled Nursing Facility staff administered the wrong medications. Review showed the resident received Levophed for blood pressure support.<br><br>During an interview on 5/3/24 at 9:30 A.M., the administrator said Certified Medication Technician (CMT) A gave Resident #2 a medication cup with his/her medication at the dining room table and did not verify the medication was taken before leaving the resident. Resident #1 and #2 sit at the same table at meals. Dietary aide B came to clean the table off and noticed the medication cups still had pills and was in the spot Resident #1 usually sits at, he/she gave the medication to RN C stating they were Resident #1's because they were in his/her usual spot. RN C gave Resident #1 the medication in the cup not realizing it was Resident #2's medication, he/she then told CMT A he/she gave Resident #1 his/her medications but CMT A had already given Resident #1's medications. RN C began monitoring the resident vitals. The resident had to be sent out for evaluation after he/she started to have adverse effects.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During an interview on 5/3/24 at 9:51 A.M., CMT A said he/she gave Resident #2 his/her pills at the breakfast table in a medication cup, he/she watched the resident take a few and walked away. He/She said after he/she finished the medication pass for the morning, he/she went on break. When he/she returned from break he/she said RN C approached him/her and said he/she gave Resident #1 his/her medication pass but he/she had given resident #1 his/her medication in the hall before break. He/She said RN C took vitals and monitored the resident until he/she had an adverse reaction and was sent to the hospital.<br><br>During an interview on 5/3/24 at 10:03 A.M., RN C said he/she was by his/her medication cart when dietary aide B called out to him/her Resident #1 forgot his/her pills on the breakfast table. He/She said the dietary aide was standing where Resident #1 usually sits and the medication cup was full of pills and looked like none had been taken. He/She said he/she did not see CMT A and Resident #1 was in his/her room so he/she gave the resident the medication in the cup. He/She said he/she informed CMT A when he/she returned from break Resident #1 had not taken his/her pills at breakfast and he/she gave him/her the pills. CMT A told him/her Resident #1 already received his/her pills in the hallway. RN A said he/she went and assessed Resident #1 and everything was baseline. Resident #1 went an activity and the weekend supervisor noticed something was off with the resident and reported it to RN C. He/She took vitals again and the resident was hypotensive and said he/she was sleepy and emergency medical services were contacted.<br><br>During an interview on 5/3/24 at 12:18 P.M., Dietary Aide B said he/she was cleaning off the tables after breakfast and Resident #1 and Resident #2 always sit together, he/she said he/she saw a cup of medication where Resident #1 usually sits. He/She said he/she gave the medication's to RN C without realizing Resident #1 and Resident #2 had switched seats.<br><br>MO00235395 |