

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555161	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER Napa Valley Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3275 Villa Lane Napa, CA 94558	

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)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41206</p> <p>Based on interviews and record reviews, the facility did not ensure residents receive treatment and care in accordance with professional standards of practice when Licensed Staff C allowed family members to administer medication to one out of two sampled residents (Resident 1). This failure was a safety risk and could potentially lead to incorrect dose administration and lack of patient education.</p> <p>Findings:</p> <p>A review of Resident 1 ' s face sheet (demographics) indicated Resident 1 was admitted on [DATE]. Her diagnoses included chronic kidney disease stage 3A (CKD, mild to moderate loss of kidney function), Cachexia (significant loss of muscle and adipose tissue- body fat) and Hyperlipidemia (HLP, high levels of fats (lipids) in your blood). A review of Resident 1 ' s Data Sheet Assessment (MDS, a standardized assessment tool that measures health status in nursing home residents) dated 5/29/24, indicated Resident 1 needed maximal assistance up to dependent on staff for provision of personal care.</p> <p>During an interview on 7/24/24 at 10:19 a.m., Licensed Staff A stated it was the facility ' s policy for medications to be administered by nurses only. Licensed Staff A stated if this was not done, it meant the facility ' s policy was not followed. Licensed Staff A stated nurses were responsible for administering medications for residents ' safety and to ensure residents were taking their medications. Licensed Staff A stated family members or responsible party (RP, person who possesses the authority to oversee and manage residents care) were not supposed to administer medications to their residents.</p> <p>During an interview on 7/24/24 at 10:28 a.m., Licensed Staff B stated nurses should be administering the medications for residents to ensure safety. Licensed Staff B stated family members or RPs should not be administering a residents ' medications.</p> <p>During an interview on 7/24/24 at 10:47 a.m., Licensed Staff C stated she left the medications to Resident 1 ' s daughter for her to administer the medication to Resident 1. Licensed Staff C stated she would occasionally leave medications for family to administer to the residents especially if the resident would not take medications from her. When asked if that was the facility ' s policy, she did not reply. Licensed Staff C stated she would leave the medications to the family or RP to administer the medications so that residents would take their medications. Licensed Staff C stated she does not always watch the resident while the medication was being administered by the RP. When asked how she knew if a resident took the medications, she was did not reply.</p> <p>(continued on next page)</p>

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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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/24/24 at 11:19 a.m., the Director of Staff Development (DSD) stated only the nurses were allowed to administer medications to the residents. The DSD stated nurses should not leave medications at bedside. The DSD stated the residents ' RP or family members were not allowed to administer medications to their residents. The DSD stated this was a safety issue.</p> <p>During an interview on 7/24/24 at 11:40 a.m., the Infection Preventionist (IP) stated it was the nurse ' s responsibility to administer medications to the residents. The IP stated RP/family members were not allowed to administer medications to their residents for safety purposes.</p> <p>During a telephone interview on 7/26/24 at 2:33 p.m., Licensed Staff D stated the nurses were the only one ' s allowed to administer medications to the residents. Licensed Staff D stated RP or family members should not administer medications to their residents for safety.</p> <p>A review of the facility ' s policy and procedure (P&P) titled Administering Medications revised 12/2012, the P&P indicated only persons licensed or permitted by this state to prepare, administer, and document the administration of medications may do so.</p> <p>Based on interviews and record reviews, the facility did not ensure residents receive treatment and care in accordance with professional standards of practice when Licensed Staff C allowed family members to administer medication to one out of two sampled residents (Resident 1). This failure was a safety risk and could potentially lead to incorrect dose administration and lack of patient education.</p> <p>Findings:</p> <p>A review of Resident 1's face sheet (demographics) indicated Resident 1 was admitted on [DATE]. Her diagnoses included chronic kidney disease stage 3A (CKD, mild to moderate loss of kidney function), Cachexia (significant loss of muscle and adipose tissue- body fat) and Hyperlipidemia (HLP, high levels of fats (lipids) in your blood). A review of Resident 1's Data Sheet Assessment (MDS, a standardized assessment tool that measures health status in nursing home residents) dated 5/29/24, indicated Resident 1 needed maximal assistance up to dependent on staff for provision of personal care.</p> <p>During an interview on 7/24/24 at 10:19 a.m., Licensed Staff A stated it was the facility's policy for medications to be administered by nurses only. Licensed Staff A stated if this was not done, it meant the facility's policy was not followed. Licensed Staff A stated nurses were responsible for administering medications for residents' safety and to ensure residents were taking their medications. Licensed Staff A stated family members or responsible party (RP, person who possesses the authority to oversee and manage residents care) were not supposed to administer medications to their residents.</p> <p>During an interview on 7/24/24 at 10:28 a.m., Licensed Staff B stated nurses should be administering the medications for residents to ensure safety. Licensed Staff B stated family members or RPs should not be administering a residents' medications.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/24/24 at 10:47 a.m., Licensed Staff C stated she left the medications to Resident 1's daughter for her to administer the medication to Resident 1. Licensed Staff C stated she would occasionally leave medications for family to administer to the residents especially if the resident would not take medications from her. When asked if that was the facility's policy, she did not reply. Licensed Staff C stated she would leave the medications to the family or RP to administer the medications so that residents would take their medications. Licensed Staff C stated she does not always watch the resident while the medication was being administered by the RP. When asked how she knew if a resident took the medications, she was did not reply.</p> <p>During an interview on 7/24/24 at 11:19 a.m., the Director of Staff Development (DSD) stated only the nurses were allowed to administer medications to the residents. The DSD stated nurses should not leave medications at bedside. The DSD stated the residents' RP or family members were not allowed to administer medications to their residents. The DSD stated this was a safety issue.</p> <p>During an interview on 7/24/24 at 11:40 a.m., the Infection Preventionist (IP) stated it was the nurse's responsibility to administer medications to the residents. The IP stated RP/family members were not allowed to administer medications to their residents for safety purposes.</p> <p>During a telephone interview on 7/26/24 at 2:33 p.m., Licensed Staff D stated the nurses were the only one's allowed to administer medications to the residents. Licensed Staff D stated RP or family members should not administer medications to their residents for safety.</p> <p>A review of the facility's policy and procedure (P&P) titled Administering Medications revised 12/2012, the P&P indicated only persons licensed or permitted by this state to prepare, administer, and document the administration of medications may do so.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46132</p> <p>Based on interviews and record reviews, the facility failed to ensure there were adequate staff to care for three out of three sampled residents (Residents 2,3 and 4) needs when:</p> <ol style="list-style-type: none"> Residents 2, 3 and 4 complained of staffs late response to call lights and late provision of care due to short staffing. Unlicensed staff statements the facility was short staffed, stating they have difficulty meeting their residents needs timely, or completing their task timely. <p>These failures resulted in:</p> <p>1a Resident 2 feeling frustrated, anxious, and afraid staff would not be available to assist her in case of a medical emergency.</p> <p>1b Resident 3 feeling frustrated and upset waiting for a long time before staff responds to call light and</p> <p>1c Resident 4 feeling unsafe and in fear something might happen to her and there would be no staff to assist her when she needed medical attention.</p> <p>These failures could also put the residents at risk for falls, injuries, accidents, late provision of care or care not being rendered at all.</p> <p>Findings:</p> <p>A review of Resident 2 ' s face sheet (demographics) indicated she was initially admitted to the facility on [DATE]. Her diagnoses included Osteoarthritis (a condition that causes joints to become painful and stiff), Hyperlipidemia (HLP, increased lipids-fats in your blood) and Insomnia (sleep disorder where you have trouble falling or staying asleep). A review of Resident 2 ' s Minimum Data Sheet Assessment (MDS, a federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes) dated 6/6/24, the Brief Interview for Mental Status (BIMS, a mandatory tool used to screen and identify the cognitive- the conscious intellectual activity, condition of resident score was 15 indicating intact cognition. Resident 2 ' s functional status indicated she required maximal staff assistance for provision of personal care.</p> <p>A review of Resident 3 ' s face sheet indicated he was initially admitted to the facility on [DATE]. His diagnoses included Muscle Weakness, Chronic Pain (persistent pain that lasts weeks to years) and adult Failure to Thrive (FTT, a decline in older adults that manifests as a downward spiral of health and ability). A review of Resident 3 ' s dated 5/7/24 score was 14 indicating intact cognition. Resident 3 needed set up and supervision when performing his activities of daily living (ADL, activities related to personal care such as bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating).</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 4 ' s face sheet indicated she was initially admitted to the facility on [DATE]. Her diagnoses included Obstructive Sleep Apnea (OSA, sleep-disordered breathing and is characterized by recurrent episodes of upper airway collapse during sleep), Anxiety Disorder (condition in which a person has excessive worry and feelings of fear, dread, and uneasiness) and Muscle Weakness. A review of Resident 4 ' s MDS, dated [DATE] indicated Resident 4 needed supervision up to maximal assistance of staff when performing her ADLs.</p> <p>During an interview on 7/24/24 at 10:19 a.m., Licensed Staff A stated staffing was an issue and sometimes there were only 2 certified nursing assistants (CNAs) scheduled per hallway. Licensed Staff A stated night shift staffing was bad. Licensed Staff A stated short staffing could contribute to call lights not being answered timely and could lead to fall and accidents. Licensed Staff A stated call lights should be answered between 3 to 5 minutes. Licensed Staff A stated call light response time beyond 5 minutes placed residents ' safety at risk.</p> <p>During an interview on 7/24/24 at 10:28 a.m., Licensed Staff B stated staffing was a struggle on all shifts. Licensed Staff B stated call light should be answered within 5 minutes. Licensed Staff B stated 15 minutes of waiting for staff to answer a call light was unacceptable and could be a safety risk. Licensed Staff B stated short staffing could be a contributing factor on why residents call light was not answered timely.</p> <p>During an interview on 7/24/24 at 10:47 a.m., Licensed Staff C stated the facility was sometimes short staffed on CNAs. Licensed Staff C stated it was difficult to complete task or answer call lights timely if each CNAs had 8 to 9 up to 12 residents in the morning shift. Licensed Staff C stated short staffing could lead to late response to call light, late provision of care, increased falls, and accidents. Licensed Staff C stated call lights should be responded to as soon as possible. Licensed Staff C stated answering call light after 15 minutes could result in falls and accidents.</p> <p>During an interview on 7/24/24 at 11:15 a.m., Unlicensed Staff G stated the facility could improve CNA staffing. Unlicensed Staff G stated short staffing could be a factor on why call lights were not answered promptly. Unlicensed Staff G stated short staffing could lead to accidents and falls. Licensed Staff G stated short staffing was a safety risk. Licensed Staff G stated call light should be answered within 5 minutes. Licensed Staff G stated if a call light was answered after 15 minutes, resident could already be on the floor or resident could have an accident.</p> <p>During an interview on 7/24/24 at 11:19 a.m., the Director of Staff Development (DSD) stated short staffing could lead to accidents, falls, skin issues, late provision of care and late response to call light. The DSD stated short staffing could be a contributing factor on why call lights were not answered as soon as possible. The DSD stated short staffing could put residents ' safety at risk. When asked how soon staff should answer a call light, the DSD stated as soon as possible. When asked if a wait time of 15 minutes or more for staff to answer call light was acceptable, the DSD stated no. The DSD stated not answering call light as soon as possible could result to falls and accidents.</p> <p>During an interview on 7/24/24 at 12:30 p.m., Resident 2 stated the facility was short staffed. Resident 2 stated staff would tell her the facility was short staffed especially when they take forever to answer her call light. Resident 2 stated she had experienced her call lights being responded to between 45 minutes up to an hour later. Resident 2 stated this was very frustrating. Resident 2 stated it makes her anxious and afraid staff would not be available to assist her in case of a medical emergency.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 7/24/24 at 12:35 p.m., Resident 3 stated staff would tell him they were short staffed. Resident 3 stated staffing was bad at night. He stated that on the rare occasion that he used his call light, staff would respond to his call light between 30 minutes up to an hour. Resident 3 stated when he asked staff why it took them a while to answer call lights, the response would be we are short staffed. Resident 3 stated waiting for a long time before staff responds to call light was very frustrating and upsetting.</p> <p>During an interview on 7/24/24 at 12:40 p.m., Resident 4 stated staff would respond to her call light between an hour up to 2 hours especially at night. She stated she suspect there were not enough staff especially at night that was why staff were not responding to her call light timely, or it could be because they were not paying attention and were just lazy. Resident 4 stated she was [AGE] years old and she feared something might happen to her and there would be no staff to assist her when she needed medical attention.</p> <p>During an interview on 7/29/24 at 8:27 a.m., Licensed Staff N stated the facility was sometimes short on CNAs. Licensed Staff N stated short staffing could contribute to call lights not being answered timely and late provision of care to the residents. Licensed Staff N stated short staffing could lead to residents fall, accidents and injuries.</p> <p>During an interview on 7/29/24 at 8:32 a.m., Unlicensed Staff L stated the facility was short staffed. Unlicensed Staff L stated she usually had 12 residents in the morning shift. Unlicensed Staff L stated it was hard to complete their task timely if they were short staffed. Unlicensed Staff L stated short staffing could lead to falls and accidents.</p> <p>During an interview on 7/29/24 at 8:35 a.m., Unlicensed Staff M stated the facility was short staffed. Unlicensed Staff M stated short staffing put residents ' safety at risk. Unlicensed Staff M stated short staffing could lead to accidents and falls. Unlicensed Staff M stated short staffing could contribute to call lights not being answered timely and late provision of care to the residents. Unlicensed Staff M stated it was tough to complete her task timely when the facility was short staffed.</p> <p>A review of the facility ' s policy and procedure (P&P) titled Answering the Call Light, revised 9/2003, to answer residents call as soon as possible .when resident is in bed be sure the call light is within easy reach of the resident .</p> <p>A review of the facility ' s P&P titled Staffing, Sufficient and Competent Nursing revised 8/2022, the P&P indicated the facility provide sufficient staff to assure resident safety .responding to their needs .attaining or maintaining the highest practicable physical, mental and psychosocial (focuses on four aspects of one's life: mental, emotional, social, and spiritual) well being of each residents .</p> <p>Based on interviews and record reviews, the facility failed to ensure there were adequate staff to care for three out of three sampled residents (Residents 2,3 and 4) needs when:</p> <ol style="list-style-type: none"> 1. Residents 2, 3 and 4 complained of staffs late response to call lights and late provision of care due to short staffing. 2. Unlicensed staff statements the facility was short staffed, stating they have difficulty meeting their residents needs timely, or completing their task timely. <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>These failures resulted in:</p> <p>1a Resident 2 feeling frustrated, anxious, and afraid staff would not be available to assist her in case of a medical emergency.</p> <p>1b Resident 3 feeling frustrated and upset waiting for a long time before staff responds to call light and</p> <p>1c Resident 4 feeling unsafe and in fear something might happen to her and there would be no staff to assist her when she needed medical attention.</p> <p>These failures could also put the residents at risk for falls, injuries, accidents, late provision of care or care not being rendered at all.</p> <p>Findings:</p> <p>A review of Resident 2's face sheet (demographics) indicated she was initially admitted to the facility on [DATE]. Her diagnoses included Osteoarthritis (a condition that causes joints to become painful and stiff), Hyperlipidemia (HLP, increased lipids-fats in your blood) and Insomnia (sleep disorder where you have trouble falling or staying asleep). A review of Resident 2's Minimum Data Sheet Assessment (MDS, a federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes) dated 6/6/24, the Brief Interview for Mental Status (BIMS, a mandatory tool used to screen and identify the cognitive- the conscious intellectual activity, condition of resident score was 15 indicating intact cognition. Resident 2's functional status indicated she required maximal staff assistance for provision of personal care.</p> <p>A review of Resident 3's face sheet indicated he was initially admitted to the facility on [DATE]. His diagnoses included Muscle Weakness, Chronic Pain (persistent pain that lasts weeks to years) and adult Failure to Thrive (FTT, a decline in older adults that manifests as a downward spiral of health and ability). A review of Resident 3's dated 5/7/24 score was 14 indicating intact cognition. Resident 3 needed set up and supervision when performing his activities of daily living (ADL, activities related to personal care such as bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating).</p> <p>A review of Resident 4's face sheet indicated she was initially admitted to the facility on [DATE]. Her diagnoses included Obstructive Sleep Apnea (OSA, sleep-disordered breathing and is characterized by recurrent episodes of upper airway collapse during sleep), Anxiety Disorder (condition in which a person has excessive worry and feelings of fear, dread, and uneasiness) and Muscle Weakness. A review of Resident 4's MDS, dated [DATE] indicated Resident 4 needed supervision up to maximal assistance of staff when performing her ADLs.</p> <p>During an interview on 7/24/24 at 10:19 a.m., Licensed Staff A stated staffing was an issue and sometimes there were only 2 certified nursing assistants (CNAs) scheduled per hallway. Licensed Staff A stated night shift staffing was bad. Licensed Staff A stated short staffing could contribute to call lights not being answered timely and could lead to fall and accidents. Licensed Staff A stated call lights should be answered between 3 to 5 minutes. Licensed Staff A stated call light response time beyond 5 minutes placed residents' safety at risk.</p> <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 7/29/24 at 8:27 a.m., Licensed Staff N stated the facility was sometimes short on CNAs. Licensed Staff N stated short staffing could contribute to call lights not being answered timely and late provision of care to the residents. Licensed Staff N stated short staffing could lead to residents fall, accidents and injuries.</p> <p>During an interview on 7/29/24 at 8:32 a.m., Unlicensed Staff L stated the facility was short staffed. Unlicensed Staff L stated she usually had 12 residents in the morning shift. Unlicensed Staff L stated it was hard to complete their task timely if they were short staffed. Unlicensed Staff L stated short staffing could lead to falls and accidents.</p> <p>During an interview on 7/29/24 at 8:35 a.m., Unlicensed Staff M stated the facility was short staffed. Unlicensed Staff M stated short staffing put residents' safety at risk. Unlicensed Staff M stated short staffing could lead to accidents and falls. Unlicensed Staff M stated short staffing could contribute to call lights not being answered timely and late provision of care to the residents. Unlicensed Staff M stated it was tough to complete her task timely when the facility was short staffed.</p> <p>A review of the facility's policy and procedure (P&P) titled Answering the Call Light , revised 9/2003, to answer residents call as soon as possible .when resident is in bed be sure the call light is within easy reach of the resident .</p> <p>A review of the facility's P&P titled Staffing, Sufficient and Competent Nursing revised 8/2022, the P&P indicated the facility provide sufficient staff to assure resident safety .responding to their needs .attaining or maintaining the highest practicable physical, mental and psychosocial (focuses on four aspects of one's life: mental, emotional, social, and spiritual) well being of each residents .</p>		

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NAME OF PROVIDER OR SUPPLIER Napa Valley Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3275 Villa Lane Napa, CA 94558	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Implement a program that monitors antibiotic use.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46132</p> <p>Based on interviews and record reviews, the facility failed to:</p> <p>1.ensure six out of nine licensed staff (Licensed Staff A,B, C, E, F and G) were aware of the facility ' s Antibiotic Stewardship Program (ASP, a coordinated program that promotes the appropriate use of antimicrobials, including antibiotics- a group of agents that share the common aim of reducing the possibility of infection and sepsis (body's extreme reaction to an infection).</p> <p>2.promote the appropriate use of antibiotics when the antibiotic was prescribed without proper indication and no attempts were made by the facility to reassess the need for continued antibiotic use for one out of two sampled residents (Resident 1) when Resident 1 received the antibiotic Augmentin ES-600 oral suspension 5 milliliters (ml, a unit of measurement) by mouth two times a day for Aspiration Pneumonia (infection of the lungs that occurs when food or liquid is breathed into the lungs instead of being swallowed) from 6/18/24 up to 6/25/24 for a total of 8 days and received the antibiotic Vancomycin oral suspension 125 milligram (mg , a unit of weight) by mouth one time daily for C.Diff prophylaxis (to prevent an illness) with oral Augmentin from 6/18/24 up to 6/25/24 [AES4] for a total of 8 days.</p> <p>These failures put the residents at risk for adverse outcomes associated with the inappropriate use of antibiotics such as infections from Clostridium difficile (C.Diff, a germ (bacterium) that causes diarrhea and colitis (an inflammation of the colon) and could be life-threatening, Candida such as oral thrush) and colonization and/or infection with antibiotic-resistant organisms such as Methicillin Resistant Staphylococcus Aureus (MRSA, a staph germ (bacteria) that does not get better with the type of antibiotics that usually cure staph infections), Vancomycin Resistant Enterococcus (VRE, superbugs that was dangerous because they were [AES6] more difficult to treat than regular infections.</p> <p>Findings:</p> <p>A review of Resident 1 ' s face sheet (demographics) indicated Resident 1 was admitted on [DATE]. Her diagnoses included Chronic Kidney Disease stage 3A (CKD, mild to moderate loss of kidney function), Cachexia (significant loss of muscle and adipose tissue) and Hyperlipidemia (HLP, high levels of fats (lipids) in your blood). A review of Resident 1 ' s Minimum Data Sheet Assessment (MDS, a standardized assessment tool that measures health status in nursing home residents) dated 5/29/24, indicated Resident 1 needed maximal up to dependent on staff for provision of personal care.</p> <p>A review of Chest X-Ray (CXR, produces images of the heart, lungs, airways, blood vessels and the bones of the spine and chest) result done on 6/18/24 indicated there was no acute Pneumonia (PNA, infection on one or both lungs).</p> <p>A review of the Infection Screening form dated 6/20/24 indicated Resident 1 had no fever, had unproductive cough and the respiratory rate was not greater than 25 breaths per minute. Although this form indicated Resident 1 had a CXR with infiltrates (any substance denser than air that could lead to lung damage), the Infection Preventionist (IP) verified this information was a typographical error.</p> <p>(continued on next page)</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 1 ' s electronic medication record (EMAR, computerized documentation system used for medication administration) for 6/2024 indicated Resident 1 received the antibiotic Augmentin ES-600 oral suspension 5 milliliters (ml, a unit of measurement) by mouth two times a day for Aspiration Pneumonia from 6/18/24 up to 6/25/24 for a total of 8 days. A review of 6/2024 EMAR also indicated Resident 1 received the antibiotic Vancomycin oral suspension 125 milligram (mg[AES13] , a unit of weight) by mouth one time daily for C.Diff prophylaxis with oral Augmentin from 6/18/24 up to 6/25/24 for a total of 8 days.</p> <p>During an interview on 7/24/24 10:19 a.m., Licensed Staff A stated she was not very familiar with the facility ' s ASP. Licensed Staff A stated usually, the physician would order the antibiotics based on laboratory test and CXR result. Licensed Staff A stated the physician ' s order for antibiotics should still be followed even if it does not have the proper indication or if the laboratory test was negative.</p> <p>During an interview on 7/24/24 at 10:28 a.m., Licensed Staff B stated he was not familiar with the facility ' s ASP and does not know which criteria needs to be met for a certain infection before an antibiotic could be prescribed.</p> <p>During an interview on 7/24/24 at 10:47 a.m., Licensed Staff C stated she does not know much about ASP. Licensed Staff C stated she thought the facility used McGeer ' s criteria (surveillance infection checklist) before initiating antibiotics. Licensed Staff C stated the resident must meet the criteria before initiating antibiotics however if the physician ordered it, they should follow the physician order. When asked what staff should do if a physician ordered an antibiotic even if it did not meet the criteria or if the laboratory test or CXR result were negative, Licensed Staff C did not respond.</p> <p>During an interview on 7/24/24 at 11:19 a.m., the Director of Staff Development (DSD) stated residents would need to meet the pneumonia infection criteria before initiating antibiotics. The DSD stated the facility had an infection screening form which they use to screen residents for infection. The DSD stated this form determines when an antibiotic was indicated to treat an infection. When asked if initiating an antibiotic therapy when a laboratory test result or CXR result was negative and the infection control screening form did not indicate resident had an active infection was appropriate, the DSD did not respond.</p> <p>(continued on next page)</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and EMAR review for 6/2024 on 7/24/24 at 11:40 a.m., the Infection Preventionist (IP) stated ASP was in place to make sure residents do not receive antibiotics unless it was indicated and to prevent antibiotic resistance. The IP verified the facility used Infection Screening form to check for symptoms and to determine whether resident have an active infection that needed to be treated with antibiotics. The IP verified Resident 1 received Augmentin ES-600 oral suspension 5 ml by mouth two times a day for Aspiration PNA from 6/18/24 up to 6/25/24 for a total of 8 days. The IP verified Resident 1 also received Vancomycin oral suspension 125 mg by mouth one time daily for C.Diff prophylaxis with oral Augmentin from 6/18/24 up to 6/25/24 for a total of 8 days. The IP verified the CXR done on 6/18/24 indicated Resident 1 had no acute PNA. The IP stated it was the physician ' s order to administer antibiotic so the staff were following the physician ' s order. When asked if this action support the facility ' s ASP, the IP did not respond. When asked if Resident 1 met the criteria for use of Augmentin, the IP stated no. When asked if Resident 1 met the criteria for active PNA, the IP stated no. When asked if a staff or the physician reassessed Resident 1 for the need to continue or discontinue the antibiotic therapy, the IP stated no. The IP verified there were no documentation to indicate Resident 1 was reassessed for continuation of antibiotic therapy despite Resident 1 not meeting the criteria for PNA. When asked what type of infection Resident 1 had to medically justify use of antibiotic therapy, the IP did not respond.</p> <p>During a telephone interview on 7/25/24 at 4:54 p.m., the pharmacy consultant (PC) stated antibiotic should only be used when it was indicated, when it met the criteria of an active infection or when there was a positive laboratory or CXR result. The pharmacist stated antibiotics could also be used empirically (with a basis in or reliance on information obtained through observation or experience) however there should be an assessment to determine if the antibiotic remains indicated or if adjustments or discontinuance to therapy should be made.</p> <p>During a telephone interview on 7/26/24 at 2:33 p.m., Licensed Staff D stated Resident 1 did not meet the indication for antibiotic usage for Aspiration PNA. Licensed Staff D verified there was no physician documentation discussing risk versus benefit of starting Resident 1 on antibiotic. Licensed Staff D verified there was no indication Resident 1 was reassessed for continued antibiotic need. Licensed Staff D stated Resident 1 had no signs and symptoms of C.Diff although Resident 1 had history of C.Diff. Licensed Staff D stated Resident 1 was started on Vancomycin to prevent development of C.Diff secondary to Augmentin use.</p> <p>During an interview on 7/29/24 at 7:40 a.m., Licensed Staff E stated she was not familiar with the facility ' s ASP. Licensed Staff E stated antibiotic usage especially if it was not indicated could lead to C.Diff infections and antibiotic resistance.</p> <p>During an interview on 7/29/24 at 7:48 a.m., Licensed Staff F stated she was not aware of the facility ' s ASP. Licensed Staff F stated antibiotic use if not indicated could hurt the resident and could result to C.Diff infection and antibiotic resistance.</p> <p>During an interview on 7/29/24 at 7:49 a.m., Licensed Staff G stated she was not aware of the facility ' s ASP.</p> <p>During an interview on 7/29/24 at 8:30 a.m., the Medical Director (MD) stated ASP was in place to ensure judicious use of antibiotics. When asked if they had discussed Resident 1 ' s antibiotic use during their ASP meeting, the MD stated they do not touch Kaiser patients.</p> <p>(continued on next page)</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the facility ' s policy and procedure (P&P) titled Pneumonia, Bronchitis (an inflammation or the body ' s response to injury, of the airways leading into your lungs) and Lower Respiratory Infections-Clinical Protocol revised 11/2018, the P&P indicated a CXR may be helpful for resident with suspected or documented PNA .</p> <p>A review of the facility ' s policy and procedure (P&P) titled Antibiotic Stewardship-Order for Antibiotics revised 12/2016, the P&P indicated the appropriate use of antibiotic include: criteria met for clinical definition of active infection .pathogen susceptibility (any organism that has a tendency to be affected) based on culture and sensitivity (C&S, a culture is a test to find germs that can caused the infection, a sensitivity test checks to see what kind of medicine or antibiotic, will work best to treat the illness or infection) .laboratory results and clinical situations will be communicated with the prescriber as soon as available to determine if antibiotic therapy should be modified or discontinued.</p> <p>Based on interviews and record reviews, the facility failed to:</p> <ol style="list-style-type: none"> 1.ensure six out of nine licensed staff (Licensed Staff A,B, C, E, F and G) were aware of the facility's Antibiotic Stewardship Program (ASP, a coordinated program that promotes the appropriate use of antimicrobials, including antibiotics- a group of agents that share the common aim of reducing the possibility of infection and sepsis (body's extreme reaction to an infection). 2.promote the appropriate use of antibiotics when the antibiotic was prescribed without proper indication and no attempts were made by the facility to reassess the need for continued antibiotic use for one out of two sampled residents (Resident 1) when Resident 1 received the antibiotic Augmentin ES-600 oral suspension 5 milliliters (ml, a unit of measurement) by mouth two times a day for Aspiration Pneumonia (infection of the lungs that occurs when food or liquid is breathed into the lungs instead of being swallowed) from 6/18/24 up to 6/25/24 for a total of 8 days and received the antibiotic Vancomycin oral suspension 125 milligram (mg , a unit of weight) by mouth one time daily for C.Diff prophylaxis (to prevent an illness) with oral Augmentin from 6/18/24 up to 6/25/24 [AES4] for a total of 8 days. <p>These failures put the residents at risk for adverse outcomes associated with the inappropriate use of antibiotics such as infections from Clostridium difficile (C.Diff, a germ (bacterium) that causes diarrhea and colitis (an inflammation of the colon) and could be life-threatening, Candida such as oral thrush) and colonization and/or infection with antibiotic-resistant organisms such as Methicillin Resistant Staphylococcus Aureus (MRSA, a staph germ (bacteria) that does not get better with the type of antibiotics that usually cure staph infections), Vancomycin Resistant Enterococcus (VRE, superbugs that was dangerous because they were [AES6] more difficult to treat than regular infections.</p> <p>Findings:</p> <p>A review of Resident 1's face sheet (demographics) indicated Resident 1 was admitted on [DATE]. Her diagnoses included Chronic Kidney Disease stage 3A (CKD, mild to moderate loss of kidney function), Cachexia (significant loss of muscle and adipose tissue) and Hyperlipidemia (HLP, high levels of fats (lipids) in your blood). A review of Resident 1's Minimum Data Sheet Assessment (MDS, a standardized assessment tool that measures health status in nursing home residents) dated 5/29/24, indicated Resident 1 needed maximal up to dependent on staff for provision of personal care.</p> <p>(continued on next page)</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Chest X-Ray (CXR, produces images of the heart, lungs, airways, blood vessels and the bones of the spine and chest) result done on 6/18/24 indicated there was no acute Pneumonia (PNA, infection on one or both lungs).</p> <p>A review of the Infection Screening form dated 6/20/24 indicated Resident 1 had no fever, had unproductive cough and the respiratory rate was not greater than 25 breaths per minute. Although this form indicated Resident 1 had a CXR with infiltrates (any substance denser than air that could lead to lung damage), the Infection Preventionist (IP) verified this information was a typographical error.</p> <p>A review of Resident 1's electronic medication record (EMAR, computerized documentation system used for medication administration) for 6/2024 indicated Resident 1 received the antibiotic Augmentin ES-600 oral suspension 5 milliliters (ml, a unit of measurement) by mouth two times a day for Aspiration Pneumonia from 6/18/24 up to 6/25/24 for a total of 8 days. A review of 6/2024 EMAR also indicated Resident 1 received the antibiotic Vancomycin oral suspension 125 milligram (mg[AES13] , a unit of weight) by mouth one time daily for C.Diff prophylaxis with oral Augmentin from 6/18/24 up to 6/25/24 for a total of 8 days.</p> <p>During an interview on 7/24/24 10:19 a.m., Licensed Staff A stated she was not very familiar with the facility's ASP. Licensed Staff A stated usually, the physician would order the antibiotics based on laboratory test and CXR result. Licensed Staff A stated the physician's order for antibiotics should still be followed even if it does not have the proper indication or if the laboratory test was negative.</p> <p>During an interview on 7/24/24 at 10:28 a.m., Licensed Staff B stated he was not familiar with the facility's ASP and does not know which criteria needs to be met for a certain infection before an antibiotic could be prescribed.</p> <p>During an interview on 7/24/24 at 10:47 a.m., Licensed Staff C stated she does not know much about ASP. Licensed Staff C stated she thought the facility used McGeer's criteria (surveillance infection checklist) before initiating antibiotics. Licensed Staff C stated the resident must meet the criteria before initiating antibiotics however if the physician ordered it, they should follow the physician order. When asked what staff should do if a physician ordered an antibiotic even if it did not meet the criteria or if the laboratory test or CXR result were negative, Licensed Staff C did not respond.</p> <p>During an interview on 7/24/24 at 11:19 a.m., the Director of Staff Development (DSD) stated residents would need to meet the pneumonia infection criteria before initiating antibiotics. The DSD stated the facility had an infection screening form which they use to screen residents for infection. The DSD stated this form determines when an antibiotic was indicated to treat an infection. When asked if initiating an antibiotic therapy when a laboratory test result or CXR result was negative and the infection control screening form did not indicate resident had an active infection was appropriate, the DSD did not respond.</p> <p>(continued on next page)</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and EMAR review for 6/2024 on 7/24/24 at 11:40 a.m., the Infection Preventionist (IP) stated ASP was in place to make sure residents do not receive antibiotics unless it was indicated and to prevent antibiotic resistance. The IP verified the facility used Infection Screening form to check for symptoms and to determine whether residents have an active infection that needed to be treated with antibiotics. The IP verified Resident 1 received Augmentin ES-600 oral suspension 5 ml by mouth two times a day for Aspiration PNA from 6/18/24 up to 6/25/24 for a total of 8 days. The IP verified Resident 1 also received Vancomycin oral suspension 125 mg by mouth one time daily for C.Diff prophylaxis with oral Augmentin from 6/18/24 up to 6/25/24 for a total of 8 days. The IP verified the CXR done on 6/18/24 indicated Resident 1 had no acute PNA. The IP stated it was the physician's order to administer antibiotic so the staff were following the physician's order. When asked if this action support the facility's ASP, the IP did not respond. When asked if Resident 1 met the criteria for use of Augmentin, the IP stated no. When asked if Resident 1 met the criteria for active PNA, the IP stated no. When asked if a staff or the physician reassessed Resident 1 for the need to continue or discontinue the antibiotic therapy, the IP stated no. The IP verified there were no documentation to indicate Resident 1 was reassessed for continuation of antibiotic therapy despite Resident 1 not meeting the criteria for PNA. When asked what type of infection Resident 1 had to medically justify use of antibiotic therapy, the IP did not respond.</p> <p>During a telephone interview on 7/25/24 at 4:54 p.m., the pharmacy consultant (PC) stated antibiotic should only be used when it was indicated, when it met the criteria of an active infection or when there was a positive laboratory or CXR result. The pharmacist stated antibiotics could also be used empirically (with a basis in or reliance on information obtained through observation or experience) however there should be an assessment to determine if the antibiotic remains indicated or if adjustments or discontinuance to therapy should be made.</p> <p>During a telephone interview on 7/26/24 at 2:33 p.m., Licensed Staff D stated Resident 1 did not meet the indication for antibiotic usage for Aspiration PNA. Licensed Staff D verified there was no physician documentation discussing risk versus benefit of starting Resident 1 on antibiotic. Licensed Staff D verified there was no indication Resident 1 was reassessed for continued antibiotic need. Licensed Staff D stated Resident 1 had no signs and symptoms of C.Diff although Resident 1 had history of C.Diff. Licensed Staff D stated Resident 1 was started on Vancomycin to prevent development of C.Diff secondary to Augmentin use.</p> <p>During an interview on 7/29/24 at 7:40 a.m., Licensed Staff E stated she was not familiar with the facility's ASP. Licensed Staff E stated antibiotic usage especially if it was not indicated could lead to C.Diff infections and antibiotic resistance.</p> <p>During an interview on 7/29/24 at 7:48 a.m., Licensed Staff F stated she was not aware of the facility's ASP. Licensed Staff F stated antibiotic use if not indicated could hurt the resident and could result to C.Diff infection and antibiotic resistance.</p> <p>During an interview on 7/29/24 at 7:49 a.m., Licensed Staff G stated she was not aware of the facility's ASP.</p> <p>During an interview on 7/29/24 at 8:30 a.m., the Medical Director (MD) stated ASP was in place to ensure judicious use of antibiotics. When asked if they had discussed Resident 1's antibiotic use during their ASP meeting, the MD stated they do not touch Kaiser patients.</p> <p>(continued on next page)</p>		

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