

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555214	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024
NAME OF PROVIDER OR SUPPLIER Professional Post Acute Center		STREET ADDRESS, CITY, STATE, ZIP CODE 81 Professional Center Parkway San Rafael, CA 94903	

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 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>49044</p> <p>Based on interview, record review, and facility policy review, the facility failed to act upon pharmacy recommendation for 1 (Resident #73) of 6 sampled residents reviewed for unnecessary medications, psychotropic medication, and medication regimen review.</p> <p>Findings included:</p> <p>A facility policy titled, Medication Regimen Review (Monthly Report), with an effective date of 06/2021, indicated, The consultant pharmacist performs a comprehensive medication regimen review (MRR) at least monthly. The MRR includes evaluating the resident's response to medication therapy to determine that the resident maintains the highest practicable level of functioning and prevents or minimizes adverse consequences related to the medication therapy. The policy directed, E. Recommendations are acted upon and documented by the facility staff and or the prescriber. 1) Physician accepts and acts upon suggestion or rejects and provides an explanation for disagreeing by the next physician visit.</p> <p>An Admission Record revealed the facility admitted Resident #73 on 09/07/2023. According to the Admission Record, the resident had a medical history that included diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, cerebral infarction due to thrombosis of right middle cerebral artery, muscle weakness, and reduced mobility.</p> <p>An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/15/2024, revealed Resident #73 had a Brief Interview for Mental Status (BIMS) of 13, which indicated the resident had intact cognition.</p> <p>Resident #73's care plan, included a focus area revised 05/20/2024, that indicated the resident had hemiplegia/ hemiparesis related to right middle artery infarct. Interventions directed staff to obtain and monitor laboratory/diagnostic work as ordered (initiated 09/08/2023).</p> <p>Resident #73's Order Summary Report, revealed an order dated 09/07/2023, for atorvastatin calcium oral tablet 80 milligrams, give one tablet by mouth at bedtime for high cholesterol and an order dated 09/07/2023, for clopidogrel bisulfate oral tablet 75 mg, give one tablet by mouth one time a day for blood thinner.</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 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Consultant Pharmacist (CP) recommendation for Resident #73 dated 07/24/2024 and signed by the physician on 08/21/2024, revealed the resident took atorvastatin and clopidogrel, and did not have a recent lipid panel, comprehensive metabolic panel (CMP), complete blood count (CBC) documented in their chart. Per the recommendation, Please consider monitoring on the next convenient lab [laboratory] day and every 6 months thereafter.</p> <p>During an interview on 09/19/2024 at 8:49 AM, the Registered Nurse (RN) Supervisor stated she did not see any orders for the laboratory work for Resident #73. The RN Supervisor confirmed the CP's recommendations for Resident #73 dated 07/24/2024 had not been implemented.</p> <p>During an interview on 09/19/2024 at 9:11 AM, the Senior Director of Clinical Operations (SDCO) stated the facility acted upon the pharmacy recommendations by placement of the recommendation in the physician's binders for the physician to sign. Per the SDCO, once the physician signed the recommendation, the nurses were to ensure the recommendations were implemented. The SDCO stated she expected the staff to follow through with the pharmacy recommendations.</p> <p>During an interview on 09/19/2024 at 9:27 AM, the Administrator stated she expected staff to follow-up on what the pharmacist recommended or requested.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>22445</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to maintain a medication error rate of 5% or less. There were two medication errors out of 27 opportunities, which yielded a medication error rate of 7.41% for 1 resident (Resident #10) of 4 residents observed for medication administration.</p> <p>Findings included:</p> <p>A facility policy titled, Administering Medications, revised 04/2023, indicated, Medication are administered in a safe and timely manner, and as prescribed. Per the policy, 9. The individual administering the medication checks the label to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.</p> <p>An Admission Record revealed the facility admitted Resident #10 on 11/05/2015. According to the Admission Record, the resident had a medical history that included diagnoses of unspecified iron deficiency anemia, presence of a right artificial knee joint, contracture of the left knee, and generalized muscle weakness.</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/06/2024, revealed Resident #10 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition.</p> <p>Resident #10's care plan included a focus area revised 04/29/2024 that indicated the resident had a history of skin breakdown related, in part, to anemia and osteoarthritis of the knee. Interventions directed the staff to administer medications as ordered. Monitor/document for side effects and effectiveness (initiated 11/06/2015).</p> <p>Resident #10's Order Summary Report that included active orders as of 09/17/2024, revealed an order dated 09/26/2018, for oyster shell calcium D tablet 500-200 milligram (mg) unit, give one tablet by mouth one time a day for supplement and an order dated 02/23/2024, for ferrous fumarate oral tablet, give 325 mg by mouth one time a day for microlytic anemia.</p> <p>During medication administration observation on 09/17/2024 at 8:32 AM, Licensed Vocational Nurse (LVN) # 1 prepared medications for Resident #10. LVN #1 placed a ferrous sulfate tablet and an oyster shell calcium tablet into the medication cup, along with Resident #10's other scheduled medications, and gave those medications to Resident #10.</p> <p>In an interview on 09/18/2024 at 11:13 AM, the Consultant Pharmacist (CP) stated the ferrous sulfate the LVN had given to Resident #10 and the physician-ordered ferrous fumarate both contained iron but included a different salt compound. The CP stated it would have been better had LVN #1 given Resident #10 what was ordered. The CP stated if he had been observing medication pass he would have counted the exchange of ferrous sulfate for ferrous fumarate as a medication error. The CP stated any medication, not given as ordered by the physician, was considered a medication error.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 09/18/2024 at 11:38 AM, LVN #1 removed the ferrous sulfate bottle used to dispense Resident #10's morning medication and compared the bottle with the physician's order. LVN #1 confirmed the physician ordered ferrous fumarate for the resident and stated she had given the resident the ferrous sulfate instead of the ferrous fumarate. LVN #1 stated she had not noticed the medications were not the same and therefore, had not reported the discrepancy to the physician or the medication error to anyone. LVN #1 then removed the calcium from the medication cart that had been given to Resident #10, reviewed the physician's order, and confirmed the order for calcium with Vitamin D. LVN #1 declined to answer why she had not given the correct medication to Resident #10, but acknowledged not giving the right medication was a medication error.</p> <p>In an interview on 09/18/2024 at 1:26 PM, the Senior Director of Clinical Operations (SDCO) stated she expected nurses to follow the rights of medication administration, which included the administration of the right medication to the resident. The SDCO stated if the medication in the medication cart did not match the medication ordered by the physician, she expected the nurse to call the physician for clarification. The SDCO stated since LVN #1 had not followed the physician's orders, LVN #1 had made a medication error.</p> <p>In an interview on 09/18/2024 at 3:11 PM, the Administrator stated that when nurses gave medications she expected the physician's orders to be followed. The Administrator stated LVN #1 made a medication error because the LVN had not followed the physician's order and had not given Resident #10 the correct medication.</p>		