STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555222	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeport Post Acute	1291 Craig Avenue Lakeport, CA 95453

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 - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** F760 (Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17) The facility must ensure that its- S483.45(f)(2) Residents are free of any significant medication errors. Based on observation, interview and record review, the facility failed to follow facility policies & procedures that required triple-checking of medication before administration which resulted in failure to administer the correct medication prescribed for one of three sampled residents (Resident 1). As a direct result, Resident 1 experienced a life-threatening adverse reaction requiring emergency rescue medications, transfer to a General Acute Care Hospital (GACH), and hospitalization in the intensive care unit for life threatening symptoms. This failure resulted in actual harm and exposed the resident to a substantial likelihood of death.A review of Resident 1's admission Record (facility demographic), indicated she was admitted to the facility on [DATE] with a primary admitting diagnosis of Parkinson's Disease (a nervous system disorder that affects movement, often causing tremors, stiffness, slowness, and balance issues).A review of Resident 1's medication order summary indicated she was prescribed Heparin Sodium (a medication to thin the blood and prevent blood clots) at a concentration of 5000 units/mL (where unit denotes a standard unit of measure and mL refers to milliliters). The regimen required administration of 1 mL of heparin every 12 hours. This order was written by a facility physician on 4/16/26.During a review of a progress note in Resident 1's medical record created by Licensed Nurse 1 (LN 1), dated 5/11/26, at 9:02 p.m., LN 1 indicated he thought he made a serious medication error at 8:05 p.m., on 5/11/26. LN 1 wrote that he may have given Resident 1 insulin instead of the ordered medication, Heparin. LN 1 also documented that Resident 1 was not diabetic (referring to Diabetes Mellitus, a chronic condition that causes increased blood sugar levels). The documentation indicated LN 1 checked Resident 1's blood sugar at 9:07 p.m., which resulted in a reading of 55 mg/dL (mg/dL means milligrams per deciliter, a standard unit of measure; normal blood sugar levels are 70-99 mg/dL when fasting) and proceeded by giving Resident 1 a peanut butter and jelly sandwich and a glass of orange juice. The note indicated LN 1 then contacted the Facility Medical Director (FMD) for a consultation. The FMD ordered a Glucagon injection (an injectable emergency medication prescribed to treat severe, dangerous low blood sugar) to be administered to Resident 1. The FMD also instructed Resident 1's blood sugar be checked every 10 minutes and that she be moved to the nurses' station, placed in a chair, and given another glass of orange juice. LN 1 documented that he called 911, and that the FMD notified the ER physician of Resident 1's status. LN 1 documented he checked Resident 1's blood sugar again, at 9:22 p.m., which resulted in 53 mg/dL, and emergency medical services arrived and transported Resident 1 from the facility to a GACH at approximately 9:48 p.m.A review Resident 1's GACH records, including emergency room (ER) records, dated 5/11/26 - 5/12/26, indicated Resident 1 received Dextrose 10% (a solution administered into a vein via a small tube, commonly used to treat severe low blood sugar levels in patients), while on route to the ER for evaluation of, Insulin [a medication to lower blood sugar] overdose. Resident 1's blood potassium level resulted in a reading of 2.8 mmol/L (millimoles per liter, a standard unit of measure; normal blood potassium levels are 3.5-5.1 mmol/L; a blood potassium level of less than 3.0 mmol/L can be life-threatening and requires urgent medical attention to avoid dangerous complications, such as (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 0760 Level of Harm - Actual harm Residents Affected - Few	abnormal heart rhythms, muscle weakness, or paralysis). Resident 1's medical record indicated her low potassium level was due to an insulin overdose and required her to be treated with potassium replacement administration. The record further indicated Resident 1's blood pressure was lower than normal likely due to her, insulin overdose. Resident 1 was administered the medication Levophed (a potent, fast-acting medication used in GACHs to treat life-threateningly low blood pressure) to treat her low blood pressure in the ER and additional intravenous (medications or fluids given through a small tube placed in a vein) fluids to maintain her blood pressure. The records indicated Resident 1 was admitted for hospitalization into the intensive care unit.During an interview on 5/13/26 at 3:15 p.m., LN 1 stated that on 5/11/26 at approximately 8:05 p.m., he administered 1 mL of the medication Insulin Lispro (a rapid acting medication prescribed to reduce a person's blood sugar level) to Resident 1 instead of her ordered Heparin injection. LN 1 stated he obtained the medication vial from the front of the medication drawer, where insulin vials were stored, instead of from the back of the drawer where Heparin vials were kept and did not verify the medication label against the physician's order before administering it. LN 1 stated he realized the error at approximately 9 p.m. and checked Resident 1's blood sugar at 9:07 p.m., which resulted in a reading of 55 mg/dL. LN 1 stated he gave Resident 1 a peanut butter and jelly sandwich and orange juice, then notified the Director of Nursing (DON) and the Facility Medical Director (FMD). LN 1 stated the FMD ordered Glucagon injection to be administered immediately, and LN 1 administered it to Resident 1 at 9:10 p.m. According to LN 1, the FMD also ordered Resident 1 to have her blood sugar checked every ten minutes, that she be moved to the nurses' station for monitoring, and that she be given additional orange juice. LN 1 stated the FMD instructed him to call 911 for transfer of Resident 1 to the GACH emergency department for evaluation and treatment, which he did upon the arrival of emergency medical services.During an interview on 5/13/26 at 3:52 p.m., Licensed Nurse 2 (LN 2) stated she worked the night shift on 5/11/26, and during LN 1's evening shift report handoff to her, LN 1 reported to her that Resident 1 was taken to the emergency room after he made a significant medication error while administering her medications during his shift. LN 1 reported to LN 2 that he administered insulin instead of Resident 1's ordered Heparin injection. LN 2 stated she called the hospital to inquire how Resident 1 was doing and see if she would be coming back to the facility during the night shift, and the emergency room nurse relayed to LN 2 that Resident 1 had a low potassium level and was being admitted to the GACH's intensive care unit for close monitoring. LN 2 stated she reported Resident 1's need for hospitalization into the intensive care unit status and low potassium level to the DON and the FMD by group text at 1:27 a.m., on 5/12/26. According to LN 2, at 1:30 a.m., on 5/12/26, the FMD responded to the group text, acknowledged LN 2's report, agreed Resident 1's hospitalization into the Intensive Care Unit was needed, and confirmed to LN 2 that a low potassium level was expected with Resident 1 being administered insulin.During an interview on 5/13/26 at 1:48 p.m., the Director of Nursing (DON) confirmed that LN 1 reported to her on 5/11/26 that he had made a significant medication error in which LN 1 administered 100 Units/1ml of Insulin Lispro to Resident 1 instead of her ordered Heparin medication, which resulted in Resident 1's hospitalization for treatment and evaluation. The DON stated LN 1 was put on a leave pending the outcome of an investigation. The DON confirmed that she expected licensed nurses to follow facility policies when administering medications to residents in the facility.During an observation of a medication administration for Resident 2 in the doorway of his room, on 5/13/26 at 11:47 a.m., Licensed Nurse 3 (LN 3) stated the first critical step in medication administration was to check the medication label on the vial against the physician's order to verify the correct medication, concentration, and dosage before drawing it into the syringe. LN 3 stated this step could not be skipped because doing so placed the resident at risk of receiving an incorrect medication, concentration, or dosage, which had the potential to cause harm.A review of the facility policy titled, Administering Medications, revised in April of 2019, indicated, Medications are administered in accordance with prescriber orders. If. a medication has been identified as having potential adverse consequences for the resident or suspected of being associated with adverse (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	consequences, the person preparing or administering the medication will contact the prescriber, the resident's attending physician or the facility's medical director to discuss the concerns The individual administering the medication checks the label THREE (3) times to verify the right resident, the right medication, right dosage. before giving the medication .A review of the facility policy titled, Adverse Consequences and Medication Errors, revised in June of 2025, indicated, A medication error is defined as the preparation or administration of drugs . which is not in accordance with provider's orders. or accepted professional standards and principles of the professional(s) providing services. A significant medication-related error is defined as. requiring hospitalization, or extending a hospitalization. requiring treatment with a prescription medication. life threatening.