

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555425	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2024
NAME OF PROVIDER OR SUPPLIER Vista Knoll Specialized Care Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 2000 Westwood Road Vista, CA 92083	

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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46980</p> <p>Based on interview and record review, the facility failed to obtain an ordered medication from its contracted pharmacy for one resident (1), who had comfort care (care given to people who are near the end of life) orders.</p> <p>As a result, Resident 1 did not receive the ordered medication to provide comfort prior to his passing (dying).</p> <p>Findings:</p> <p>Resident 1 was admitted to the facility on [DATE] with diagnoses that included acute kidney failure (a condition in which the kidneys lose their ability to filter waste from the blood), pneumonia (an infection that affects the lungs), COPD (Chronic Obstructive Pulmonary Disease, a progressive lung disease that causes breathing problems), heart failure (a condition in which the heart does not pump enough blood for the needs of the body), Parkinson ' s disease (a brain disorder that causes uncontrolled movements such as shaking, stiffness and difficulty with balance), and Alzheimer ' s Disease (a progressive irreversible brain disorder that affects memory, thinking and language).</p> <p>On 7/31/24 the State Agency (SA) received a complaint which indicated Medical Doctor (MD) 1 determined (Resident 1) was at the end of his life, and ordered morphine (an opiate narcotic pain reliever) for comfort care. At approximately 11:30 A.M., Registered Nurse (RN) 1 confirmed that MD 1 ordered morphine (for Resident 1) and that she would administer it (the morphine) soon. Resident 1 passed away at approximately 2:30 P.M. and never received the morphine.</p> <p>On 8/13/24 at 11:30 A.M. an interview and concurrent medical record review was conducted with the Assistant Director of Nursing (ADON). The ADON stated, (Resident 1) was prescribed a comfort pack like hospice (comfort and quality of life care provided to a person with a serious illness who is approaching the end of life) patients. There was an order for morphine liquid every hour as needed for pain and shortness of breath, Levsin (a medication to help decrease saliva) and Ativan (a medication to help decrease anxiety) every four hours.</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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview with the ADON was conducted on 8/22/24 at 15:45 P.M. The ADON stated, There is no documentation that the pharmacy was contacted to release the medication. I was not aware there was a problem getting the medication. I probably should have just helped them out more. None of the ordered medications were administered. Ativan was in the emergency kit (a collection of medications available in urgent circumstances) but was not given (to Resident 1) . The ADON referred to a facility document that indicated, Pharmacy will perform deliveries at least three (3) times per day, 7 days a week, Monday through Sunday. Pharmacy will also provide emergency deliveries as requested by Facility. The ADON stated there was no evidence to prove the facility requested emergency delivery of the morphine solution.</p> <p>On 8/23/24 at 3:51 P.M. an interview was conducted with the Director of Nursing (DON) who stated, The standard of care is to make sure the resident is comfortable. Whatever medication was ordered by the physician should be given. It would actually help the resident to have the medication, at least the Ativan that was in the facility.</p> <p>On 8/26/24 at 11:33 A.M., an interview was conducted with RN 1 who stated, The doctor ordered the medications to make (Resident 1) comfortable. The Ativan was in the emergency kit . I did not offer the Ativan.</p> <p>On 8/27/24 at 8:50 A.M. a telephone interview was conducted with the owner of the contracted facility pharmacy who stated, The morphine order was faxed (facsimile; method of transmitting scanned material or text via telephone line) to us. There was no physician signature and no quantity. We received it on 7/28/24 12:53 P.M. from the facility, not the prescriber, and went into our queue (order list of messages). (MD 2) instructed the pharmacy not to contact via phone on weekends, but to contact the answering service or use eScript (a digital version of a prescription for medication). We sent an eScript at 1:56 P.M. The assumption is that if the physician wants something sent electronically hopefully someone is monitoring. For an urgent need we would need to get a phone call from the facility to alert us. I don ' t have any notes that the facility alerted us. If it ' s a phone call that came in, we just take care of it, we don ' t document it. There ' s no indication on the fax that the medication was urgently needed.</p> <p>A review of the facility policy titled, Provider Pharmacy Requirements effective January 2022 indicated, Regular and reliable pharmaceutical services is available to provide residents with prescription and nonprescription medications, services, and related equipment and supplies.The provider pharmacy is responsible for rendering the required service in accordance with local, state, and federal laws and regulations; facility policies and procedures; community standards of practice; and professional standards of practice. The provider pharmacy agrees to perform the following pharmaceutical services, including but not limited to: .accurately dispensing prescriptions based on authorized prescriber orders.Providing routine and timely pharmacy service as contracted, and pharmacy service 24 hours per day, seven days per week.</p> <p>An interview was conducted with the DON on 8/26/24 at 4:22 P.M. The DON stated that the Ativan should have been given. Further, the DON stated, Nobody called the pharmacy to speed up the process of releasing the morphine. The medications were not given, the needs of the resident were not met.</p>		