

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555486	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/02/2025
NAME OF PROVIDER OR SUPPLIER Alameda Healthcare & Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE 430 Willow Street Alameda, CA 94501	

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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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** Based on observation, interview and record review, the facility failed to provide enough nursing staff to provide timely medication administration and prevent medication errors when five of eight sampled residents (Residents 1, 2, 3, 4 and 5) did not receive medications according to physician orders and resident care plans.</p> <p>This failure resulted in:</p> <ol style="list-style-type: none"> 1. Licensed Vocational Nurse 1 (LVN 1) administering 12 medications late to Resident 1 which included a medication to manage seizures (episodes of uncontrolled and abnormal firing of brain cells that may cause changes in attention or behavior such as bodily movements) which had the potential to increase Resident 1 ' s risk of seizure, 2. Registered Nurse 2 (RN 2) administered a dose of methadone (medication to control pain) five times higher than ordered by the provider to Resident 2 which placed Resident 2 at risk of narcotic (substances that have an accepted medical use, medications which fall under US Drug Enforcement Agency (DEA) Schedules II&mdash;V, and have a potential for abuse, ranging from low to high, and may also lead to physical or psychological dependence) overdose potentially leading to death, 3. Licensed Vocational Nurse 3 (LVN 3) administered 11 medications late to Resident 3 which included medications to control blood pressure and prevent blood clots which placed Resident 3 at risk of high blood pressure and formation of blood clots which could lead to death, 4. Registered Nurse 1 (RN 1) administered 10 medications late to Resident 4 which included a medication to prevent blood clots which placed Resident 4 at risk of formation of blood clot which could lead to death, and 5. LVN 1 administered 13 medications late to Resident 5 which included medications to manage pain which had the potential for Resident 5 to experience uncontrolled pain. <p>Findings:</p> <p>A review of Resident 1 ' s admission record indicated Resident 1 was admitted for epilepsy (a brain disorder in which a person has repeated seizures over time), supraventricular tachycardia (condition which causes a high heart rate), muscle weakness and dysphagia (difficulty swallowing).</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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a record review of Resident 1 ' s minimum data set (MDS, an assessment tool to guide resident care), dated 4/21/25, the MDS indicated Resident 1 had Brief Interview for Mental Status score of 11 (BIMS, is a scoring system used to determine the resident ' s cognitive status in regard to attention, orientation, and ability to register and recall information. A BIMS score of eight to twelve indicates a moderate cognitive impairment.)</p> <p>During a record review of Resident 1 ' s physicians orders set titled, [Facility] Order Summary Report, dated 5/19/25, indicated Resident 1 did not have an order to self-administer medications and was not capable of making medical decisions. The physicians order set indicated Resident 1 had an order for levetiracetam (medication to prevent seizures) 500 mg 1 tablet twice a day for seizures.</p> <p>During a review of Resident 1 ' s care plan titled, Care Plan Report, undated, the care plan indicated Resident 1 had a care plan for alteration in neurological status related to seizure .give medications as ordered, dated 5/18/24. The care plan further indicated Resident 1 had a care plan for altered cardiovascular status as supraventricular tachycardia .medication per MD order, dated 4/21/22.</p> <p>During a concurrent observation and interview on 5/13/25, at 9:30 a.m., with Resident 1, two medication cups with one cup containing a red liquid and a second cup containing 12 tablets were on Resident 1 ' s bedside table. One of the tablet medications was a large yellow oval tablet with E and 11 engraved on one side. Above Resident 1 ' s bed was a sign indicating seizure precautions encourage resident to eat, drink and medication. Resident 1 stated she was waiting for food to take her medications and no one had come in to help her take her medications. Resident 1 stated the pills had been on the table since the morning.</p> <p>During an observation of a medication pass on 5/13/25, at 10:07 a.m. with LVN 1, LVN 1 was performing a medication pass on Resident 5. Resident 5 received 13 medications with the medication pass finishing at 10:37 a.m., and LVN 1 continued to pass medications on another resident.</p> <p>During an observation on 5/13/25, at 11:12 a.m., in Resident 1 ' s room, the two medication cups were still on Resident 1 ' s bedside table. Resident 1 was asleep in bed with the bedside table positioned over her. Inside the medication cup were the same 12 medications. There were no staff in the room.</p> <p>During a concurrent observation and interview on 5/13/25, at 11:38 a.m., with LVN 1, LVN 1 was in Resident 1 ' s room giving Resident 1 the medications which were on the bedside table. LVN 1 stated they had placed Resident 1 ' s medications on the bedside table because Resident 1 was not ready to take the medications yet. LVN 1 stated Resident 1 did not have difficulty taking medications. An inspection of Resident 1 ' s medications in the medication cart indicated the yellow oval tablet with an E and 11 engraving was a levetiracetam 500 mg tablet. LVN 1 stated the levetiracetam tablet needed to be given on time to prevent seizures. LVN 1 stated they attempted to give Resident 1 their medications at 8:00 a.m., 8:30 a.m., and finally administered the levetiracetam tablet at 10:30 a.m.</p> <p>During a record review of Resident 1 ' s medication administration record (MAR), the MAR indicated Resident 1 ' s morning medication pass includeded of 12 medications in tablet form. The MAR indicated portions 12 medications were given at various times with four medications given at 7:48 a.m, four medications given at around 9:32 a.m., and three medications given at around 10:05 a.m. The MAR indicated levetiracetam 500 mg tablet was given at 9:32 a.m The MAR did not indicate any of the 12 medications were given at around 11:38 a.m.</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 - Few</p>	<p>During a record review of facility staffing sheet titled, [Facility] Nursing Staff Assignment and Sign-in Sheet, dated 5/13/25, and facility census titled, [Facility] Daily Census, dated 5/13/25, comparison of LVN 1 ' s assignment to the census indicated LVN 1 had 26 patients to pass medications for.</p> <p>A review of Resident 2 ' s admission record indicated Resident 2 was admitted for acute heart failure (disease which causes reduced heart function), dementia (a loss of brain function that occurs with certain diseases, affecting one or more brain functions such as memory, thinking, language, judgment, or behavior) and failure to thrive.</p> <p>During a record review of Resident 2 ' s physician order set titled, [Facility] Order Summary Report, dated 5/16/25, the order set indicated Resident 2 had an order for methadone oral tablet 5 mg give 5 mg by mouth two times a day for pain, dated 3/10/25.</p> <p>During a record review of Resident 2 ' s medication admission record titled, [Facility] Medication Admin Audit Report, dated 5/16/25, the record indicated on 3/12/25, at 9:28 a.m., RN 2 gave Resident 2 methadone.</p> <p>During a record review of Resident 2 ' s narcotics count sheet titled, Narcotics Count Sheet methadone 5 mg, dated 3/2025, the count sheet indicated five tablets of methadone was removed on 3/12/25.</p> <p>During a phone interview on 5/14/25, at 2:30 p.m., with RN 2, RN 2 stated on 3/12/25, she was beginning to perform a medication pass for Resident 2. RN 2 stated she had been distracted with the needs of another resident and while rushing to prepare Resident 2 ' s medication she mistakenly gave Resident 2 the wrong dose of methadone. RN 2 stated Resident 2 received 5 tablets of 5 mg methadone instead of 1 tablet of 5 mg methadone and only realized the error the following day when performing a narcotics count.</p> <p>During a review of Resident 2 ' s nursing progress notes titled, [Facility] Progress notes, dated 5/16/25, the progress notes indicated on 3/13/25, RN 2 wrote a progress note writer contacted [hospice] regarding medication administration error for methadone 5mg. Writer stated that they gave 5 tablets instead of 5 mg of methadone. The progress notes indicated on 3/12/25, RN 2 wrote a late entry change of condition note indicating Writer administered 5 tablets of methadone 5mg, instead of prescribed 1 tablet of methadone 5mg.</p> <p>During a record review of facility staffing sheet titled, [Facility] Nursing Staff Assignment and Sign-in Sheet, dated 3/12/25 and facility census titled, [Facility] Daily Census, dated 3/12/25, comparison of RN 1 ' s assignment to the census indicated RN 1 had 25 patients to pass medications for.</p> <p>During an interview on 5/16/25, at 9:33 a.m., with the Director of Nursing, the DON stated RN 2 was assisting another resident and became distracted when she prepared the medications for Resident 2. The DON stated RN 2 was educated on reading medication orders accurately and had three medication passes observed by consultants to ensure RN 2 was reading medication orders accurately. The DON stated distractions during medication preparation and administration can be a cause of medication errors, and there was no plan to address distractions during medication administration. The DON stated educating the nurses to read labels and to be cognizant of time were the two main interventions to prevent medication errors and to give medications on time.</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 - Few</p>	<p>A review of Resident 3 ' s admission record indicated Resident 3 was admitted in 2021 for diabetes, paraplegia (the loss of muscle function in the lower part of the body including both legs), muscle weakness and need for assistance with personal care.</p> <p>During a record review of Resident 3 ' s MDS, dated [DATE], the MDS indicated Resident 3 had Brief Interview for Mental Status score of 15 (BIMS, is a scoring system used to determine the resident ' s cognitive status in regard to attention, orientation, and ability to register and recall information. A BIMS score of thirteen to fifteen is an indication of intact cognitive status.)</p> <p>During a record review of Resident 3 ' s physicians order set titled, [Facility] Order Summary Report, dated 5/16/25, the order set indicated Resident 3 had an order for metoprolol (a medication to manage blood pressure) .tablet extended release 24 hour 100 mg. Give 1 tablet by mouth one time a day for [hypertension] and an order for diltiazem (a medication to manage blood pressure) .oral capsule extended release 12 hour 120mg. Give 1 capsule by mouth one time a day for [hypertension].</p> <p>During a record review of Resident 3 ' s care plan titled, Care plan Report, The resident is at risk for altered cardiovascular status, undated, the care plan indicated the following interventions: metoprolol succinate ER as ordered. Diltiazem as ordered.</p> <p>During a concurrent observation and interview on 5/16/25, at 10:40 a.m., LVN 3 was in Resident 3 ' s room performing a medication pass. LVN 3 stated Resident 3 had his medication pass performed late because there were 28 residents to pass medications for. LVN 3 stated they started their medication pass at 8:00 a.m. and needed to stop frequently to find a CNA when residents were asking for help. LVN 3 stated they would appreciate assistance with medication passes but didn ' t have anyone in the immediate area to call for. LVN 3 stated the nursing supervisor last checked in with her at 9:00 a.m.</p> <p>During an interview on 5/16/25, at 2:20 p.m., with Resident 3, Resident 3 stated he received his medications on 5/16/25, at around 10:30 a.m Resident 3 stated the day shift nurses usually gave his morning medications close to lunch. Resident 3 stated many nurses would give meds late and document the meds were given on time, and when he complained about the practice, the staff looked at the documentation and said the medications were given on time. Resident 3 stated the way his concern was dismissed by the facility caused him to consider about how he would rather be back in prison.</p> <p>During a record review of facility staffing sheet titled, [Facility] Nursing Staff Assignment and Sign-in Sheet, dated 5/16/25 and facility census titled, [Facility] Daily Census, dated 5/16/25, comparison of LVN 3 ' s assignment to the census indicated LVN 1 had 27 patients to pass medications for.</p> <p>During an interview on 5/16/25, at 2:20 p.m., with Resident 3, Resident 3 stated he received his medications on 5/16/25, at around 10:30 a.m Resident 3 stated the day shift nurses usually gave his medications late. When asked if nurses would give meds late and document the meds were given on time, Resident 3 ' s eyes widened and stated this is what many of the nurses do, and when he makes a complaint, the staff look at the documentation and say it was given on time. Resident 3 stated the way he is treated at the facility he would rather be back in prison.</p> <p>A review of Resident 3 ' s medication administration record titled, [Facility] Medication Admin Audit Report, dated 5/16/25, indicated LVN 3 gave Resident 3:</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 - Few</p>	<p>1. eight medications on 5/16/25, at 10:40 a.m. with three medications scheduled to be given at 8:00 a.m. and five medications scheduled to be given at 9:00 a.m.</p> <p>2. three medications at 10:48 a.m with one medication, diltiazem due at 8:00 a.m. and two medications including a metoprolol due at 9:00 a.m.</p> <p>A review of Resident 4 ' s admission record indicated Resident 4 was admitted to the facility in 2023 with femur (long bone in leg) fracture, pulmonary embolism (obstruction of blood vessels in the lungs causing loss of blood flow to lungs and heart), anemia (low blood), cognitive communication deficit and muscle weakness.</p> <p>During a record review of Resident 4 ' s physician order set titled, [Facility] Order Summary Report, dated 5/16/25, the order set indicated Resident 4 had an order for apixaban oral tablet 2.5 mg Give 1 tablet .two times a day for Acute Pulmonary embolism which was dated 3/6/24.</p> <p>A review of Resident 4 ' s care plan titled, Care Plan Report, undated, indicated Resident 4 had a care plan which indicated resident is on anticoagulant apixaban r/t pulmonary embolism .administer anticoagulant medications as ordered by physician.</p> <p>During a concurrent interview and record review on 5/16/25, at 10:50 a.m., with Registered Nurse 1 (RN 1), Resident 3 ' s medication administration record (MAR) was reviewed. RN 1 stated Resident 4 ' s medication administration for the morning was not completed yet. RN 1 stated Resident 4 had medications that needed to be given on time such as cardiac medications. RN 1 stated he was late getting medications done because he had to attend to residents which a CNA could not assist with such as preparing tube feeding setups and getting appointments confirmed for residents. RN 1 stated he had 25 residents to pass medications for and most of the medications were due at 9:00 a.m. RN 1 stated there was one nursing supervisor available for help.</p> <p>During a record review of facility staffing sheet titled, [Facility] Nursing Staff Assignment and Sign-in Sheet, dated 5/16/25 and facility census titled, [Facility] Daily Census, dated 5/16/25, comparison of RN 1 ' s assignment to the census indicated RN 1 had 25 patients to pass medications for.</p> <p>A review of Resident 4 ' s MAR titled, [Facility] Medication Admin Audit Report, dated 5/16/25, indicated on 5/16/25, RN 1 gave Resident 3:</p> <p>1. seven medications at approximately 11:00 a.m. with two medications due at 8:00 a.m., four medications were due at 9:00 a.m. and one was due at 11:00 a.m.,</p> <p>2. three medications at approximately 11:15 a.m. which all three medications were due at 9:00 a.m.</p> <p>A review of Resident 5 ' s admission record indicated Resident 5 was admitted in 2020 with diagnoses of osteoporosis (condition characterized by weakened bone structure), chronic pain syndrome, anxiety, muscle weakness and need for assistance with personal care.</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 - Few</p>	<p>During a record review of Resident 5 ' s physician order set titled, [Facility] Order Summary Report, dated 5/16/25, the order set indicated Resident 5 had orders for baclofen (medication to relax muscles) 10mg tab Give 1 tablet .for chronic pain, cymbalta (medication which can be used to manage pain symptoms) oral capsule 20 mg .Give 1 capsule .for chronic pain syndrome, gabapentin (medication to manage pain) oral tablet 600 mg .give 1 tablet .for neuropathic pain.</p> <p>During a record review of Resident 5 ' s MAR titled, [Facility] Medication Admin Audit Report, dated 5/13/25, indicated Resident 5 received 13 medications at approximately 10:44 a.m. with six medications due at 9:00 a. m. which included cymbalta and gabapentin, and seven medications due at 8:00 a.m. which included Baclofen.</p> <p>During an interview on 5/16/25, at 11:30 a.m., with the Assistant Director of Nursing (ADON), the ADON stated they were acting as the nursing supervisor because there were no nursing supervisors hired by the facility. The ADON stated she tried to round on nurses every two hours but would expect nurses to ask for help with medication administration if needed. The ADON stated no nurses on the current shift came to ask for help.</p> <p>During an interview on 5/16/25, at 2:00 p.m., with the DON, the DON stated medication passes were expected to take less than 10 minutes per resident. The DON stated facility staffing of the nurses was not at her expected level and had difficulty in requesting corporate owners to supply more nurses. The DON stated there were no nursing supervisors on staff for the long term care section of the facility which required the ADON and admissions nurse to fill in nurse supervisor duties. The DON stated medications needed to be given on time to maintain therapeutic effectiveness and was important for medications such as seizure medications, blood pressure medications and anti-coagulants. The DON stated they could not expect nursing staff to administer medications safely and effectively under 5 minutes while having to attend to resident needs.</p> <p>During a concurrent interview and record review on 5/16/25, at 2:30 p.m., with the DON, the facility medication administration QAPI program document titled, [DATE], dated 10/2024, was reviewed. The DON stated the facility had implemented a QAPI program to reduce medication errors and ensure medications were given on time. The document indicated licensed nurses lack education on medication administration policy and procedure. The DON stated they did not investigate whether distractions and staffing levels had impact on medication error or late medication administration.</p> <p>During a phone interview on 6/2/25, at 5:30 p.m., with pharmacy consultant (PC), the PC stated they had replaced the previous PC. The PC stated on the week of 3/13/25, they started to work at the facility and was given notes by the previous PC. The PC stated they were not aware of any medication errors made since they started in March. The PC stated the standards in administering levetiracetam was two doses a day to ensure stable levels of the medication throughout the day and give a dose more than 3.5 hours late was too late.</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 - Few</p>	<p>A review of facility policy and procedure (P&P) titled, Medication Administration, dated 01/2012, the P&P indicated the licensed nurse will prepare medications within one hour of administration. Medications may be administered one hour before or after the scheduled medication administration time .whenever a medication is held .the licensed nurse will document .the time and reason the medication was held .the licensed nurse will attempt to give the medication several times, but if the resident continues to refuse after one hour, the refused medication will be destroyed. The P&P further indicated nursing staff will keep in mind the seven rights of medication when administering medication .the right amount .the right time.</p>		

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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>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** Based on observation, interview and record review, the facility failed to ensure quality of care for five of eight sampled residents (Residents 1, 2, 3, 4 and 5) when staff did not provide medications according to physician 's order and resident care plan.</p> <p>This failure resulted in:</p> <ol style="list-style-type: none"> 1. Licensed Vocational Nurse 1 (LVN 1) administering 12 medications late to Resident 1 which included a medication to manage seizures (episodes of uncontrolled and abnormal firing of brain cells that may cause changes in attention or behavior such as bodily movements) which had the potential to increase Resident 1 ' s risk of seizure, 2. Registered Nurse 2 (RN 2) administered a dose of methadone (medication to control pain) five times higher than ordered by the provider to Resident 2 which placed Resident 2 at risk of narcotic (substances that have an accepted medical use, medications which fall under US Drug Enforcement Agency (DEA) Schedules II&mdash;V, and have a potential for abuse, ranging from low to high, and may also lead to physical or psychological dependence) overdose potentially leading to death, 3. Licensed Vocational Nurse 3 (LVN 3) administered 11 medications late to Resident 3 which included medications to control blood pressure and prevent blood clots which placed Resident 3 at risk of high blood pressure and formation of blood clots which could lead to death, 4. Registered Nurse 1 (RN 1) administered 10 medications late to Resident 4 which included a medication to prevent blood clots which placed Resident 4 at risk of formation of blood clot which could lead to death, and 5. LVN 1 administered 13 medications late to Resident 5 which included medications to manage pain which had the potential for Resident 5 to experience uncontrolled pain. <p>Findings:</p> <p>A review of Resident 1 ' s admission record indicated Resident 1 was admitted for epilepsy (a brain disorder in which a person has repeated seizures over time), supraventricular tachycardia (condition which causes a high heart rate), muscle weakness and dysphagia (difficulty swallowing).</p> <p>During a record review of Resident 1 ' s minimum data set (MDS, an assessment tool to guide resident care), dated 4/21/25, the MDS indicated Resident 1 had Brief Interview for Mental Status score of 11 (BIMS, is a scoring system used to determine the resident ' s cognitive status in regard to attention, orientation, and ability to register and recall information. A BIMS score of eight to twelve indicates a moderate cognitive impairment.)</p> <p>During a record review of Resident 1 ' s physicians orders set titled, [Facility] Order Summary Report, dated 5/19/25, indicated Resident 1 did not have an order to self-administer medications and was not capable of making medical decisions. The physicians order set indicated Resident 1 had an order for levetiracetam (medication to prevent seizures) 500 mg 1 tablet twice a day for seizures.</p> <p>(continued on next page)</p>		

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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>During a review of Resident 1 ' s care plan titled, Care Plan Report, undated, the care plan indicated Resident 1 had a care plan for alteration in neurological status related to seizure .give medications as ordered, dated 5/18/24. The care plan further indicated Resident1 had a care plan for altered cardiovascular status as supraventricular tachycardia .medication per MD order, dated 4/21/22.</p> <p>During a concurrent observation and interview on 5/13/25, at 9:30 a.m., with Resident 1, two medication cups with one cup containing a red liquid and a second cup containing 12 tablets were on Resident 1 ' s bedside table. One of the tablet medications was a large yellow oval tablet with E and 11 engraved on one side. Above Resident 1 ' s bed was a sign indicating seizure precautions encourage resident to eat, drink and medication. Resident 1 stated she was waiting for food to take her medications and no one had come in to help her take her medications. Resident 1 stated the pills had been on the table since the morning.</p> <p>During an observation of a medication pass on 5/13/25, at 10:07 a.m., with LVN 1, LVN 1 was performing a medication pass on Resident 5. Resident 5 received 13 medications with the medication pass finishing at 10:37 a.m., and LVN 1 continued to pass medications on another resident.</p> <p>During an observation on 5/13/25, at 11:12 a.m., in Resident 1 ' s room, the two medication cups were still on Resident 1 ' s bedside table. Resident 1 was asleep in bed with the bedside table positioned over her. Inside the medication cup were the same 12 medications. There were no staff in the room.</p> <p>During an interview on 5/13/25, at 11:25 a.m., with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated Resident 1 had their breakfast at around 7 to 8 a.m.</p> <p>During a concurrent observation and interview on 5/13/25, at 11:38 a.m., with LVN 1, LVN 1 was in Resident 1 ' s room giving Resident 1 the medications which were on the bedside table. LVN 1 stated they had placed Resident 1 ' s medications on the bedside table because Resident 1 was not ready to take the medications yet. LVN 1 stated Resident 1 did not have difficulty taking medications. An inspection of Resident 1 ' s medications in the medication cart indicated the yellow oval tablet with an E and 11 engraving was a levetiracetam 500 mg tablet. LVN 1 stated the levetiracetam tablet needed to be given on time to prevent seizures. LVN 1 stated they attempted to give Resident 1 their medications at 8:00 a.m., 8:30 a.m., and finally administered the levetiracetam tablet at 10:30 a.m.</p> <p>During a record review of Resident 1 ' s medication administration record (MAR), the MAR indicated Resident 1 ' s morning medication pass consisted of 12 medications in tablet form. The MAR indicated portions 12 medications were given at various times with four medications given at 7:48 a.m, four medications given at around 9:32 a.m., and three medications given at around 10:05 a.m. The MAR indicated levetiracetam 500 mg tablet was given at 9:32 a.m The MAR did not indicate any of the 12 medications were given at around 11:38 a.m.</p> <p>A review of Resident 2 ' s admission record indicated Resident 2 was admitted for acute heart failure (disease which causes reduced heart function), dementia (a loss of brain function that occurs with certain diseases, affecting one or more brain functions such as memory, thinking, language, judgment, or behavior) and failure to thrive.</p> <p>(continued on next page)</p>

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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>During a record review of Resident 2 ' s physician order set titled, [Facility] Order Summary Report, dated 5/16/25, the order set indicated Resident 2 had an order for methadone oral tablet 5 mg give 5 mg by mouth two times a day for pain, dated 3/10/25.</p> <p>During a record review of Resident 2 ' s medication admission record titled, [Facility] Medication Admin Audit Report, dated 5/16/25, the record indicated on 3/12/25, at 9:28 a.m., RN 2 gave Resident 2 methadone tablet 5mg.</p> <p>During a record review of Resident 2 ' s narcotics count sheet titled, Narcotics Count Sheet methadone 5 mg, dated 3/2025, the count sheet indicated five tablets of methadone were removed on 3/12/25 for the 9:28 a.m. medication pass.</p> <p>During a phone interview on 5/14/25, at 2:30 p.m., with RN 2, RN 2 stated on 3/12/25, she was beginning to perform a medication pass for Resident 2. RN 2 stated she had been distracted with the needs of another resident and while rushing to prepare Resident 2 ' s medication, she mistakenly gave Resident 2 the wrong dose of methadone. RN 2 stated Resident 2 received 5 tablets of 5 mg methadone instead of 1 tablet of 5 mg methadone and only realized the error the following day when performing a narcotics count.</p> <p>During a review of Resident 2 ' s nursing progress notes titled, [Facility] Progress notes, dated 5/16/25, the progress notes indicated on 3/13/25, RN 2 wrote a progress note writer contacted [hospice] regarding medication administration error for methadone 5mg. Writer stated that they gave 5 tablets instead of 5 mg of methadone. The progress notes indicated on 3/12/25, RN 2 wrote a late entry change of condition note indicating Writer administered 5 tablets of methadone 5mg, instead of prescribed 1 tablet of methadone 5mg.</p> <p>During an interview on 5/16/25, at 9:33 a.m., with the Director of Nursing, the DON stated RN 2 was assisting another resident and was distracted when she prepared the medications. The DON stated distractions during medication preparation and administration can be a cause of medication errors, and there was no plan to address distractions during medication administration.</p> <p>A review of Resident 3 ' s admission record indicated Resident 3 was admitted in 2021 for diabetes, paraplegia (the loss of muscle function in the lower part of the body including both legs), muscle weakness and need for assistance with personal care.</p> <p>During a record review of Resident 3 ' s MDS, dated [DATE], the MDS indicated Resident 3 had Brief Interview for Mental Status score of 15 (BIMS, is a scoring system used to determine the resident ' s cognitive status in regard to attention, orientation, and ability to register and recall information. A BIMS score of thirteen to fifteen is an indication of intact cognitive status.)</p> <p>During a record review of Resident 3 ' s physicians order set titled, [Facility] Order Summary Report, dated 5/16/25, the order set indicated Resident 3 had an order for metoprolol (a medication to manage blood pressure) .tablet extended release 24 hour 100 mg. Give 1 tablet by mouth one time a day for [hypertension] and an order for diltiazem (a medication to manage blood pressure) .oral capsule extended release 12 hour 120mg. Give 1 capsule by mouth one time a day for [hypertension].</p> <p>(continued on next page)</p>		

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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>During a record review of Resident 3 ' s care plan titled Care plan Report, undated, the care plan indicated the resident is at risk for altered cardiovascular status .interventions: metoprolol succinate ER as ordered. Diltiazem as ordered.</p> <p>During a concurrent observation and interview on 5/16/25, at 10:40 a.m., LVN 3 was in Resident 3 ' s room performing a medication pass. LVN 3 stated Resident 3 had his medication pass performed late because there were 28 residents to pass medications for. LVN 3 stated they started their medication pass at 8:00 a.m. and needed to stop frequently to find a CNA when residents were asking for help. LVN 3 stated they would appreciate assistance with medication passes but didn ' t have anyone in the immediate area to call for. LVN 3 stated the nursing supervisor last checked in with her at 9:00 a.m.</p> <p>During an interview on 5/16/25, at 2:20 p.m., with Resident 3, Resident 3 stated he received his medications on 5/16/25, at around 10:30 a.m Resident 3 stated the day shift nurses usually gave his morning medications close to lunch. Resident 3 stated many nurses would give meds late and document the meds were given on time, and when he complained about the practice, the staff looked at the documentation and said the medications were given on time. Resident 3 stated the way his concern was dismissed by the facility caused him to consider about how he would rather be back in prison.</p> <p>A review of Resident 3 ' s medication administration record titled, [Facility] Medication Admin Audit Report, dated 5/16/25, indicated on 5/16/25, LVN 3 gave Resident 3:</p> <ol style="list-style-type: none"> 1. eight medications at 10:40 a.m. with three medications scheduled to be given at 8:00 a.m. and five medications scheduled to be given at 9:00 a.m. 2. three medications at 10:48 a.m with one medication, diltiazem due at 8:00 a.m. and two medications including a metoprolol due at 9:00 a.m. <p>A review of Resident 4 ' s admission record indicated Resident 4 was admitted to the facility in 2023 with femur (long bone in leg) fracture, pulmonary embolism (obstruction of blood vessels in the lungs causing loss of blood flow to lungs and heart), anemia (low blood), cognitive communication deficit and muscle weakness.</p> <p>During a record review of Resident 4 ' s MDS, dated [DATE], the MDS indicated Resident 4 had Brief Interview for Mental Status score of 1 (BIMS, is a scoring system used to determine the resident ' s cognitive status in regard to attention, orientation, and ability to register and recall information. A BIMS score of zero to seven is an indication of severe impairment to cognitive status.)</p> <p>During a record review of Resident 4 ' s physician order set titled, [Facility] Order Summary Report, dated 5/16/25, the order set indicated Resident 4 had an order for apixaban oral tablet 2.5 mg Give 1 tablet .two times a day for Acute Pulmonary embolism which was dated 3/6/24.</p> <p>A review of Resident 4 ' s care plan titled, Care Plan Report, undated, indicated Resident 4 had a care plan which indicated resident is on anticoagulant apixaban r/t pulmonary embolism .administer anticoagulant medications as ordered by physician.</p> <p>(continued on next page)</p>		

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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>During a concurrent interview and record review on 5/16/25, at 10:50 a.m., with RN 1, Resident 4 ' s medication administration record (MAR) was reviewed. RN 1 stated Resident 4 ' s medication administration for the morning was not completed yet. RN 1 stated Resident 4 had medications that needed to be given on time such as cardiac and anticoagulant medications. RN 1 stated he was late getting medications done because he had to attend to residents which a CNA could not assist with, such as preparing tube feeding setups and getting appointments confirmed for residents. RN 1 stated they had 25 residents to pass medications for and the majority of medications were due at 9:00 a.m. RN 1 stated there was one nursing supervisor for the long term care section of the facility.</p> <p>A review of Resident 4 ' s MAR titled, [Facility] Medication Admin Audit Report, dated 5/16/25, indicated on 5/16/25, RN 1 gave Resident 3:</p> <ol style="list-style-type: none"> seven medications at approximately 11:00 a.m. with two medications due at 8:00 a.m., four medications were due at 9:00 a.m. and one was due at 11:00 a.m., three medications at approximately 11:15 a.m. which all three medications were due at 9:00 a.m. <p>A review of Resident 5 ' s admission record indicated Resident 5 was admitted in 2020 with diagnoses of osteoporosis (condition characterized by weakened bone structure), chronic pain syndrome, anxiety, muscle weakness and need for assistance with personal care.</p> <p>During a record review of Resident 5 ' s physician order set titled, [Facility] Order Summary Report, dated 5/16/25, the order set indicated Resident 5 had orders for baclofen (medication to relax muscles) 10mg tab Give 1 tablet .for chronic pain, cymbalta (medication which can be used to manage pain symptoms) oral capsule 20 mg .Give 1 capsule .for chronic pain syndrome, gabapentin (medication to manage pain) oral tablet 600 mg .give 1 tablet .for neuropathic pain.</p> <p>During a record review of Resident 5 ' s MAR titled, [Facility] Medication Admin Audit Report, dated 5/13/25, indicated Resident 5 received 13 medications at approximately 10:44 a.m. with six medications due at 9:00 a. m. which included cymbalta and gabapentin, and seven medications due at 8:00 a.m. which included Baclofen.</p> <p>During an interview on 5/16/25, at 11:30 a.m., with the Assistant Director of Nursing (ADON), the ADON stated they were acting as the nursing supervisor because there were no nursing supervisors hired by the facility. The ADON stated she tried to round on nurses every two hours but would expect nurses to ask for help with medication administration if needed.</p> <p>During an interview on 5/16/25, at 2:00 p.m., with the Director of Nursing (DON), the DON stated medication passes were expected to take 10-15 minutes per resident. The DON stated facility staffing of the nurses was not at her expected level. The DON stated medications needed to be given on time to maintain therapeutic effectiveness and was important for medications such as seizure medications, blood pressure medications and anti-coagulants. The DON stated they could not expect nursing staff to administer medications safely and effectively under 5 minutes while having to attend to resident needs.</p> <p>(continued on next page)</p>		

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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>During a phone interview on 6/2/25, at 5:30 p.m., with pharmacy consultant (PC), the PC stated they had replaced the previous PC. The PC stated on the week of 3/13/25, they started to work at the facility and was given notes by the previous PC. The PC stated they were not aware of any medication errors made since they started in March. The PC stated the standards in administering levetiracetam was two doses a day to ensure stable levels of the medication throughout the day and give a dose more than 3.5 hours late was too late.</p> <p>A review of facility policy and procedure (P&P) titled, Medication Administration, dated 01/2012, the P&P indicated the licensed nurse will prepare medications within one hour of administration. Medications may be administered one hour before or after the scheduled medication administration time .whenever a medication is held .the licensed nurse will document .the time and reason the medication was held .the licensed nurse will attempt to give the medication several times, but if the resident continues to refuse after one hour, the refused medication will be destroyed. The P&P further indicated nursing staff will keep in mind the seven rights of medication when administering medication .the right amount .the right time.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>Based on observation, interview and record review, the facility failed to ensure one of eight sampled residents (Resident 2) were free from significant medication errors when Registered Nurse 2 (RN 2) administered a dose of methadone (a narcotic medication to control pain [narcotics are substances that have an accepted medical use, medications which fall under US Drug Enforcement Agency (DEA) Schedules II&mdash;V, and have a potential for abuse, ranging from low to high, and may also lead to physical or psychological dependence]) five times higher than ordered by the provider to Resident 2, who had received narcotic medications before and after the medication error.</p> <p>This failure resulted in Resident 2 vomiting and placed Resident 2 at risk of narcotic overdose potentially leading to death.</p> <p>Findings:</p> <p>A review of Resident 2 ' s admission record indicated Resident 2 was admitted for acute heart failure (disease which causes reduced heart function), dementia (a loss of brain function that occurs with certain diseases, affecting one or more brain functions such as memory, thinking, language, judgment, or behavior) and failure to thrive.</p> <p>During a record review of Resident 2 ' s physician order set titled, [Facility] Order Summary Report, dated 5/16/25, the order set indicated Resident 2 had an order for methadone oral tablet 5 mg (milligram, unit of measurement) give 5 mg by mouth two times a day for pain, dated 3/10/25, an order for hydromorphone (a narcotic medication, belonging to the same class of medications as methadone, for pain) oral liquid 1 mg/mL(unit of measurement of medication concentration) .give 1mL by mouth every 4 hours as needed, dated 3/10/25, and an order for hydromorphone oral liquid 1 mg/mL give 4 mL by mouth every 1 hour as needed for pain, dated 3/10/25.</p> <p>During a record review of Resident 2 ' s medication admission record (MAR) titled, [Facility] Medication Admin Audit Report, dated 5/16/25, the MAR indicated on 3/12/25, at 9:28 a.m., RN 2 gave Resident 2 methadone tablet 5 mg. The MAR indicated on 3/12/25, Resident 2 received one dose of hydromorphone oral liquid .give 1 ml by mouth at 6:38 a.m., one dose of hydromorphone oral liquid .give 4 mL by mouth at 12:26 p.m., and a dose of methadone tablet 5 mg at 4:06 p.m</p> <p>During a record review of Resident 2 ' s narcotics count sheet titled, Narcotics Count Sheet methadone 5 mg, dated 3/2025, the count sheet indicated five tablets of methadone was removed on 3/12/25 for the 9:28 a.m. medication pass and one tablet of methadone was removed on 3/12/25 for the 4:00 p.m. medication pass.</p> <p>During a phone interview on 5/14/25, at 2:30 p.m., with RN 2, RN 2 stated on 3/12/25, she was beginning to perform a medication pass for Resident 2. RN 2 stated she had been distracted with the needs of another resident and while rushing to prepare Resident 2 ' s medication, she mistakenly gave Resident 2 the wrong dose of methadone. RN 2 stated Resident 2 received 5 tablets of 5 mg methadone instead of 1 tablet of 5 mg methadone and only realized the error the following day when performing a narcotics count. RN 2 stated facility staff monitored Resident 2 for narcotics overdose once the medication error was discovered.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 2 ' s nursing progress notes titled, [Facility] Progress notes, dated 5/16/25, the progress notes indicated on 3/13/25, RN 2 wrote a progress note writer contacted [hospice] regarding medication administration error for methadone 5mg. Writer stated that they gave 5 tablets instead of 5 mg of methadone. The progress notes indicated on 3/12/25, RN 2 wrote a late entry change of condition note indicating Writer administered 5 tablets of methadone 5mg, instead of prescribed 1 tablet of methadone 5mg. The progress notes indicated on 3/13/25, RN 2 wrote a note indicating family of resident informed writer that resident was throwing up. Writer observed resident gagging.</p> <p>During a phone interview on 5/30/25, at 9:00 a.m., with resident representative (RP), the RP stated they were contacted by the facility on 3/13/25 about Resident 2 ' s medication error. When RP was with Resident 2, Resident 2 began to vomit while attempting to eat a sandwich. The RP stated Resident 2 appeared over-sedated when they were with Resident 2.</p> <p>During an interview on 5/16/25, at 9:33 a.m., with the Director of Nursing, the DON stated RN 2 was assisting another resident and was distracted when she prepared the medications for Resident 2. The DON stated the medication error should have been discovered during the narcotic count during the night of 3/12/25.</p> <p>A review of facility policy and procedure (P&P) titled, Medication Administration, dated 01/2012, the P&P indicated nursing staff will keep in mind the seven rights of medication when administering medication .the right amount .the right time.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>Based on observation, interview and record review, the facility failed to maintain proper storage of medications including controlled medications (substances that have an accepted medical use, medications which fall under US Drug Enforcement Agency (DEA) Schedules II&mdash;V, and have a potential for abuse, ranging from low to high, and may also lead to physical or psychological dependence) when the medication room for the sub-acute area was left unlocked and a refrigerator containing an emergency kit (e-kit, kit containing doses of emergency medication) which contained one vial of lorazepam (a controlled medication which is used for sedation)] was also left unlocked.</p> <p>This failure to adequately secure medications had the potential for drug diversion and unauthorized access to medications.</p> <p>Findings:</p> <p>During an observation on 5/13/25, at 9:38 a.m., the medication room of the sub-acute area was inspected. The door was closed and had a number coded lock on the door. Without entering any code, the door could be opened. Inside the medication room was a refrigerator with an unlocked keyed padlock hanging on a hinge. Inside the refrigerator was an e-kit containing a vial of lorazepam.</p> <p>During a concurrent observation and interview on 5/13/25, at 9:38 a.m., with Nurse Supervisor 1 (NS 1), the medication room in the sub-acute area was examined. NS 1 stated e-kits were stored in a locked refrigerator in the medication room. NS 1 stated a mechanism which kept the door unlocked was engaged. NS 1 disengaged the mechanism and left the room with the refrigerator remaining unlocked.</p> <p>During an interview on 5/19/25, at 4:30 p.m., with the Director of Nursing (DON), the DON stated all medication rooms and medication storage needed to be locked at all times to prevent unauthorized access to medications.</p> <p>A review of facility policy and procedure (P&P) titled, Medication Storage in the Facility, dated 1/2025, indicated, the medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized controlled medications are stored separately from other medications in a double locked compartment designated for that purpose.</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility quality assurance committee failed to adequately and effectively implement the QAPI program when a QAPI project to reduce medication errors and prevent late medication administration was not fully implemented, did not adequately address the cause of late medication administration and errors, did not monitor and did not reassess or change the program interventions when medication errors and late medication administrations continued for five of eight sampled residents (Resident 1, 2, 3, 4 and 5) and potentially for all residents in the facility.</p> <p>This failure resulted in:</p> <ol style="list-style-type: none"> Licensed Vocational Nurse 1 (LVN 1) administering 12 medications late to Resident 1 which included a medication to manage seizures (episodes of uncontrolled and abnormal firing of brain cells that may cause changes in attention or behavior such as bodily movements) which had the potential to increase Resident 1 ' s risk of seizure, Registered Nurse 2 (RN 2) administered a dose of methadone (medication to control pain) five times higher than ordered by the provider to Resident 2 which placed Resident 2 at risk of narcotic (substances that have an accepted medical use, medications which fall under US Drug Enforcement Agency (DEA) Schedules II&mdash;V, and have a potential for abuse, ranging from low to high, and may also lead to physical or psychological dependence) overdose potentially leading to death, Licensed Vocational Nurse 3 (LVN 3) administered 11 medications late to Resident 3 which included medications to control blood pressure and prevent blood clots which placed Resident 3 at risk of high blood pressure and formation of blood clots which could lead to death, Registered Nurse 1 (RN 1) administered 10 medications late to Resident 4 which included a medication to prevent blood clots which placed Resident 4 at risk of formation of blood clot which could lead to death, and LVN 1 administered 13 medications late to Resident 5 which included medications to manage pain which had the potential for Resident 5 to experience uncontrolled pain. <p>Findings:</p> <p>A review of Resident 1 ' s admission record indicated Resident 1 was admitted for epilepsy (a brain disorder in which a person has repeated seizures over time), supraventricular tachycardia (condition which causes a high heart rate), muscle weakness and dysphagia (difficulty swallowing).</p> <p>During a record review of Resident 1 ' s minimum data set (MDS, an assessment tool to guide resident care), dated 4/21/25, the MDS indicated Resident 1 had Brief Interview for Mental Status score of 11 (BIMS, is a scoring system used to determine the resident ' s cognitive status in regard to attention, orientation, and ability to register and recall information. A BIMS score of eight to twelve indicates a moderate cognitive impairment.)</p> <p>(continued on next page)</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a record review of Resident 1 ' s physicians orders set titled, [Facility] Order Summary Report, dated 5/19/25, indicated Resident 1 did not have an order to self-administer medications and was not capable of making medical decisions. The physicians order set indicated Resident 1 had an order for levetiracetam (medication to prevent seizures) 500 mg 1 tablet twice a day for seizures.</p> <p>During a review of Resident 1 ' s care plan titled, Care Plan Report, undated, the care plan indicated Resident 1 had a care plan for alteration in neurological status related to seizure .give medications as ordered, dated 5/18/24. The care plan further indicated Resident1 had a care plan for altered cardiovascular status as supraventricular tachycardia .medication per MD order, dated 4/21/22.</p> <p>During a concurrent observation and interview on 5/13/25, at 9:30 a.m., with Resident 1, two medication cups with one cup containing a red liquid and a second cup containing 12 tablets were on Resident 1 ' s bedside table. One of the tablet medications was a large yellow oval tablet with E and 11 engraved on one side. Above Resident 1 ' s bed was a sign indicating seizure precautions encourage resident to eat, drink and medication. Resident 1 stated she was waiting for food to take her medications and no one had come in to help her take her medications. Resident 1 stated the pills had been on the table since the morning.</p> <p>During an observation of a medication pass on 5/13/25, at 10:07 a.m., with LVN 1, LVN 1 was performing a medication pass on Resident 5. Resident 5 received 13 medications with the medication pass finishing at 10:37 a.m., and LVN 1 continued to pass medications on another resident.</p> <p>During an observation on 5/13/25, at 11:12 a.m., in Resident 1 ' s room, the two medication cups were still on Resident 1 ' s bedside table. Resident 1 was asleep in bed with the bedside table positioned over her. Inside the medication cup were the same 12 medications. There were no staff in the room.</p> <p>During a concurrent observation and interview on 5/13/25, at 11:38 a.m., with LVN 1, LVN 1 was in Resident 1 ' s room giving Resident 1 the medications which were on the bedside table. LVN 1 stated they had placed Resident 1 ' s medications on the bedside table because Resident 1 was not ready to take the medications yet. LVN 1 stated Resident 1 did not have difficulty taking medications. An inspection of Resident 1 ' s medications in the medication cart indicated the yellow oval tablet with an E and 11 engraving was a levetiracetam 500 mg tablet. LVN 1 stated the levetiracetam tablet needed to be given on time to prevent seizures. LVN 1 stated they attempted to give Resident 1 their medications at 8:00 a.m., 8:30 a.m., and finally administered the levetiracetam tablet at 10:30 a.m.</p> <p>During a record review of Resident 1 ' s medication administration record (MAR), the MAR indicated Resident 1 ' s morning medications included 12 medications in tablet form. The MAR indicated portions of the 12 medications were given at various times with four medications given at 7:48 a.m, four medications given at around 9:32 a.m., and three medications given at around 10:05 a.m. The MAR indicated levetiracetam 500 mg tablet was given at 9:32 a.m The MAR did not indicate any of the 12 medications were given at around 11:38 a.m.</p> <p>A review of Resident 2 ' s admission record indicated Resident 2 was admitted for acute heart failure (disease which causes reduced heart function), dementia (a loss of brain function that occurs with certain diseases, affecting one or more brain functions such as memory, thinking, language, judgment, or behavior) and failure to thrive.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Alameda Healthcare & Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE 430 Willow Street Alameda, CA 94501	

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a record review of Resident 3 ' s physicians order set titled, [Facility] Order Summary Report, dated 5/16/25, the order set indicated Resident 3 had an order for metoprolol (a medication to manage blood pressure) .tablet extended release 24 hour 100 mg. Give 1 tablet by mouth one time a day for [hypertension] and an order for diltiazem (a medication to manage blood pressure) .oral capsule extended release 12 hour 120mg. Give 1 capsule by mouth one time a day for [hypertension].</p> <p>During a record review of Resident 3 ' s care plan titled, Care plan Report, undated, the care plan indicated the resident is at risk for altered cardiovascular status .interventions: metoprolol succinate ER as ordered. Diltiazem as ordered.</p> <p>During a concurrent observation and interview on 5/16/25, at 10:40 a.m., LVN 3 was in Resident 3 ' s room performing a medication pass. LVN 3 stated Resident 3 had his medication pass performed late because there were 28 residents to pass medications for. LVN 3 stated they started their medication pass at 8:00 a.m. and needed to stop frequently to find a CNA when residents were asking for help. LVN 3 stated they would appreciate assistance with medication passes but didn ' t have anyone in the immediate area to call for. LVN 3 stated the nursing supervisor last checked in with her at 9:00 a.m.</p> <p>During an interview on 5/16/25, at 2:20 p.m., with Resident 3, Resident 3 stated he received his medications on 5/16/25, at around 10:30 a.m Resident 3 stated the day shift nurses usually gave his morning medications close to lunch. Resident 3 stated many of the nurses would give meds late and document the meds were given on time, and when he complained about the practice, the staff looked at the documentation and said the medications were given on time. Resident 3 stated the way his concern was dismissed by the facility caused him to consider about how he would rather be back in prison.</p> <p>A review of Resident 3 ' s medication administration record titled, [Facility] Medication Admin Audit Report, dated 5/16/25, indicated on 5/16/25, LVN 3 gave Resident 3:</p> <ol style="list-style-type: none"> 1. eight medications at 10:40 a.m. with three medications scheduled to be given at 8:00 a.m. and five medications scheduled to be given at 9:00 a.m. 2. three medications at 10:48 a.m with one medication, diltiazem due at 8:00 a.m. and two medications including a metoprolol due at 9:00 a.m. <p>A review of Resident 4 ' s admission record indicated Resident 4 was admitted to the facility in 2023 with femur (long bone in leg) fracture, pulmonary embolism (obstruction of blood vessels in the lungs causing loss of blood flow to lungs and heart), anemia (low blood), cognitive communication deficit and muscle weakness.</p> <p>During a record review of Resident 4 ' s MDS, dated [DATE], the MDS indicated Resident 4 had Brief Interview for Mental Status score of 1 (a BIMS score of zero to seven is an indication of severe impairment to cognitive status).</p> <p>During a record review of Resident 4 ' s physician order set titled, [Facility] Order Summary Report, dated 5/16/25, the order set indicated Resident 4 had an order for apixaban oral tablet 2.5 mg Give 1 tablet .two times a day for Acute Pulmonary embolism which was dated 3/6/24.</p> <p>(continued on next page)</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 4 ' s care plan titled, Care Plan Report, undated, indicated Resident 4 had a care plan which indicated resident is on anticoagulant apixaban r/t pulmonary embolism .administer anticoagulant medications as ordered by physician.</p> <p>During a concurrent interview and record review on 5/16/25, at 10:50 a.m., with RN 1, Resident 4 ' s medication administration record (MAR) was reviewed. RN 1 stated Resident 4 ' s medication administration for the morning was not completed yet. RN 1 stated Resident 4 had medications that needed to be given on time such as cardiac and anticoagulant medications. RN 1 stated he was late getting medications done because he had to attend to residents which a CNA could not assist with, such as preparing tube feeding setups and getting appointments confirmed for residents. RN 1 stated they had 25 residents to pass medications for and the majority of medications were due at 9:00 a.m. RN 1 stated there was one nursing supervisor for the long term care section of the facility.</p> <p>A review of Resident 4 ' s MAR titled, [Facility] Medication Admin Audit Report, dated 5/16/25, indicated on 5/16/25, RN 1 gave Resident 3:</p> <ol style="list-style-type: none"> seven medications at approximately 11:00 a.m. with two medications due at 8:00 a.m., four medications were due at 9:00 a.m. and one was due at 11:00 a.m., three medications at approximately 11:15 a.m. which all three medications were due at 9:00 a.m. <p>A review of Resident 5 ' s admission record indicated Resident 5 was admitted in 2020 with diagnoses of osteoporosis (condition characterized by weakened bone structure), chronic pain syndrome, anxiety, muscle weakness and need for assistance with personal care.</p> <p>During a record review of Resident 5 ' s physician order set titled, [Facility] Order Summary Report, dated 5/16/25, the order set indicated Resident 5 had orders for baclofen (medication to relax muscles) 10mg tab Give 1 tablet .for chronic pain, cymbalta (medication which can be used to manage pain symptoms) oral capsule 20 mg .Give 1 capsule .for chronic pain syndrome, gabapentin (medication to manage pain) oral tablet 600 mg .give 1 tablet .for neuropathic pain.</p> <p>During a record review of Resident 5 ' s MAR titled, [Facility] Medication Admin Audit Report, dated 5/13/25, indicated Resident 5 received 13 medications at approximately 10:44 a.m. with six medications due at 9:00 a. m. which included cymbalta and gabapentin, and seven medications due at 8:00 a.m. which included Baclofen.</p> <p>(continued on next page)</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 5/16/25, at 2:30 p.m., with the DON, the facility medication administration QAPI program document titled, [DATE], dated 10/2024, was reviewed. The DON stated the facility had implemented a QAPI program to reduce medication errors and ensure medications were given on time. The document indicated licensed nurses lack education on medication administration policy and procedure. The DON stated they did not investigate whether distractions and staffing levels had an impact on medication error or late medication administration. The DON stated the identification of medication errors and late medication administration relied on the nurses to complete a Change of Condition documentation whenever a medication error or late medication administration occurred. The DON stated the QAPI plan indicated a pharmacy consultant would review Change of Condition documentations for medication errors and an education in-service on medication administration policy would occur and the relevant nurse would have medication passes supervised. The QAPI program document indicated The DON . conducted an audit of all medication orders of residents in SAU to ensure that medications are administered as ordered .will conduct a review of 5 resident medication administration records .in SAU weekly x 4 weeks then bimonthly for 2 months until substantial compliance is achieved to ensure medications are administered as ordered. The DON stated they did not perform checks of medication administration records or audit for additional residents potentially as outlined in the QAPI program.</p> <p>During a phone interview on 6/2/25, at 5:30 p.m., with pharmacy consultant (PC), the PC stated they had replaced the previous PC. The PC stated on the week of 3/13/25, they started to work at the facility and was given notes by the previous PC. The PC stated the notes instructed them to meet with the administrator to ensure they were included on the quarterly quality assurance (QA) meetings. The PC stated they did not attend the April quarterly QA meeting because they were not familiar with the facility. The PC stated they were not aware of any medication errors made since they started in March and was not aware of any QAPI plans regarding medication administration or medication errors.</p> <p>A review of facility policy and procedure titled, QAPI01 Quality Assurance and Performance Improvement (QAPI) Program, dated 6/4/24, indicated the facility implements and maintains an ongoing, facility-wide [QAPI] program designed to .pursue methods to improve quality of care, and resolve identified issues .the facility evaluates the effectiveness of its QAPI program .as needed .the QAPI committee evaluates .to help define issues, plan and implement actions, and ensure monitoring and follow-up.</p>		