STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555524	A. Building B. Wing	09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Health Care Ctr at the Forum at Rancho San Antonio	23600 via Esplendor Cupertino, CA 95014

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37686 Based on interview and record review, the facility failed to ensure care and services were provided in accordance with professional standards of practice for one of three sample residents (Resident 1) when: 1. The facility scheduled a change in medication administration time to start on 7/17/24 when it should have started on 7/18/24; and, 2. A medication was documented as administered when it should have been documented as refused. These failures had the potential to compromise the resident's health and well-being. Findings: 1. Review of Resident 1's medical record indicated she was admitted on [DATE] and had diagnoses including hypertension (high blood pressure). Review of Resident 1's Order Summary Report indicated she had a physician's order, dated 7/8/24, for lisinopril (medication used to lower blood pressure) 5 milligrams (mg, unit of dose measurement) three tablets (total of 15 mg) by mouth one time a day for hypertension. From 7/9/24 to 7/17/24, this medication was scheduled to be administered at 9:00 a.m. Review of Resident 1's medication administration record (MAR) indicated on 7/17/24, Resident 1 received her daily dose of lisinopril as ordered at 9:00 a.m. Review of Resident 1's Progress Notes, dated 7/17/24, indicated Resident 1's physician saw her at 11:00 a. m. and gave a new order to administer lisinopril in the evening. The Progress Notes indicated, Order noted and carried out. Review of Resident 1's Order Details, dated 7/17/24, indicated a staff member carried out a new order for lisinopril 5 mg three tablets by mouth every day for hypertension. The staff member scheduled an administration time of 5:00 p.m., with a start date of 7/17/24. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and concurrent record review with the director of nursing (DON) on 9/6/24, at 10:44 a.m., the DON reviewed Resident 1's medical record and confirmed the new evening administration time for Resident 1's daily dose of lisinopril was scheduled to start at 5:00 p.m. on 7/17/24. The DON acknowledged that per documentation, Resident 1 had already received her daily dose of lisinopril at 9:00 a.m. that day. The DON confirmed Resident 1's new administration time for lisinopril should have been scheduled to start the following day, 7/18/24. During an interview with registered nurse A (RN A) on 9/6/24, at 2:50 p.m., RN A confirmed she was the one who carried out the physician's order to start administering Resident 1's lisinopril in the evening. RN A confirmed that when she carried out the order on 7/17/24, she had already administered Resident 1's daily dose of lisinopril at 9:00 a.m. that day. RN A confirmed the new evening administration time for Resident 1's daily dose of lisinopril was supposed to be scheduled to start the following day, 7/18/24. RN A stated, That was my mistake. 2. Review of Resident 1's Order Summary Report indicated she had a physician's order, dated 7/8/24, for lisinopril 5 mg three tablets by mouth one time a day for hypertension. From 7/9/24 to 7/17/24, this medication was scheduled to be administered at 9:00 a.m. Review of Resident 1's MAR indicated on 7/17/24, Resident 1 received her daily dose of lisinopril as ordered at 9:00 a.m. Review of Resident 1's Progress Notes, dated 7/17/24, indicated Resident 1's physician saw her at 11:00 a. m. and gave a new order to administer lisinopril in the evening. The Progress Notes indicated, Order noted and carried out. Review of Resident 1's Order Details, dated 7/17/24, indicated a staff member carried out a new order for lisinopril 5 mg three tablets by mouth every day for hypertension. The staff member scheduled an administration time of 5:00 p.m., with a start date of 7/17/24. Further review of Resident 1's MAR was conducted. The documentation indicated Resident 1 also received lisinopril 5 mg three tablets by mouth at 5:00 p.m. on 7/17/24. During an interview and concurrent record review with the DON on 9/6/24, at 10:44 a.m., the DON reviewed Resident 1's MAR and confirmed the documentation indicated that on 7/17/24, Resident 1 received lisinopril 5 mg three tablets by mouth at 9:00 a.m. and 5:00 p.m. During an interview with RN A on 9/6/24, at 2:50 p.m., RN A confirmed she administered lisinopril 5 mg three tablets by mouth to Resident 1 on 7/17/24 at 9:00 a.m. RN A explained later that day, Resident 1's physician gave an order to start administering lisinopril in the evening. RN A further explained when she entered the new order in the computer system, she mistakenly scheduled the evening lisinopril to start at 5:00 p.m. on 7/17/24 instead of the following day. RN A stated that on 7/17/24, the evening nurse tried to administer the 5:00 p.m. dose of lisinopril to Resident 1, but the resident refused it because she had already taken the medication at 9:00 a.m. that morning. During a follow-up interview and concurrent record review with the DON on 9/6/24, at 2:52 p.m., the DON stated if Resident 1 refused to take lisinopril on 7/17/24 at 5:00 p.m., this should have been documented in the medical record. The DON reviewed Resident 1's medical record and confirmed there was no documentation that indicated Resident 1 refused lisinopril on 7/17/24 at 5:00 p.m. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy titled Administering Medications, dated 2001, indicated if a medication is withheld or refused, the individual administering the medication shall initial and circle the MAR space provided for that medication and dose. The facility's policy titled Documentation of Medication Administration, revised 11/2022, indicated to document the reasons why a medication was withheld, not administered, or refused.