STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555727	A. Building B. Wing	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurel Creek Health Center	2800 Estates Drive Fairfield, CA 94533

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46132 Based on interviews and record reviews, the facility failed to ensure one out of two sampled resident (Resident 1) did not develop a pressure ulcer when the facility did not follow their policy and procedure for prevention of pressure injuries such as inspecting the skin daily when performing or assisting with personal care or activities of daily living (ADL, tasks of everyday life), did not continually evaluate Resident 1 ' s potential for skin breakdown per physician ' s order and request a preventative treatment prescribed by the physician once Resident 1 became incontinent of both bladder (the ability to control on when to empty the urine)and bowel function (the ability to control when to have a bowel movement). These failures resulted to Resident 1 acquiring a stage 2 pressure ulcer (PU, a shallow open ulcer with a red or pink wound bed, caused when an area of skin is placed under pressure). Findings: A review of Resident 1 face sheet (demographics) indicated he was admitted on [DATE] with a diagnoses of Essential Hypertension (HTN, high blood pressure), Hyperlipidemia (HLP, an elevated level of lipids like cholesterol and triglycerides in your blood) and Type 2 Diabetes Mellitus (DM, a disease that occurs when your blood glucose, also called blood sugar, is too high). (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	His Minimum Data Sheet Assessment (MDS, a federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes) dated 1/23/24 Brief Interview for Mental Status (BIMS, a mandatory tool used to screen and identify the cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) condition of residents, indicated Resident 1 had a short term and long-term memory impairment. Resident 1 ' s MDS assessment also indicated he was always incontinent of both bladder and bowel. His MDS assessment also indicated Resident 1 had 1 unhealed pressure ulcer when he was discharged at the facility on 1/23/24. Resident 1 ' s admission note dated 1/2/24 22:34 indicated the admission skin assessment was done, and the coccyx (tailbone) and bony prominences (areas where bones are close to the surface and areas that are under the most pressure are at greatest risk for developing pressure sores) were intact. His skin Interdisciplinary Team (IDT, professional disciplines, as appropriate, will work together to provide the greatest benefit for the resident) note dated 1/22/24 13:58 indicated Resident 1 was noted with a Stage 2 PU on his left buttock. A review of Resident 1 ' s PO indicated there was no order for preventive treatment once Resident 1 became incontinent of bowel and bladder function. Further review of Resident 1 ' s Physician Order (PO, the instruction the physician had written for a resident ' s treatment) dated 1/2/24, indicated to complete the Braden Scale assessment (a standardized, evidence-based assessment tool commonly used in health care to assess and document a patient's risk for developing pressure ulcer) upon admission and then weekly for the next 4 weeks. There was only 1 Braden Scale Skin Assessment completed dated 1/3/24, the score was 17, indicating Resident 1 had a mild risk for developing pressure ulcer. As per Braden Scale Skin assessment dated [DATE], Resident 1 ' s skin was occasionally moist, walks occasionally during the day but for very short distance, had slight limited ability to change and control body position, had inadequate food intake, and issue with friction and shear during movement in bed or chair. There were no further Braden Scale Skin Assessment completed after 1/3/24. A review of Resident 1 ' s ADL charting did not indicate he was being offered toileting or incontinence care every 2 hours. There were no documentations provided to indicate Resident 1 was being turned and repositioned every 2 hours. During an interview on 2/20/24 at 10:12 a.m., Unlicensed Staff A stated it was the facility ' s policy to ensure residents were turned and repositioned every 2 hours to offload weight and to check and change incontinent residents every 2 hours or more often as needed. Unlicensed Staff A stated staff would also apply a barrier cream on residents who were incontinent. Unlicensed Staff A stated not doing these could result to development of pressure sores, open wounds, pain and infections. During an interview on 2/20/24 at 10:30 a.m., Licensed Staff B stated it was the facility ' s P&P with pressure sore prevention to turn and reposition residents every 2 hours as needed and as tolerated and to check and change incontinent residents every 2 hours or more often as needed. Licensed Staff B stated residents who were incontinent were more prone to develop pressure ulcer so it was important to initiate a preventive treatment per physician ' s order. Licensed Staff B stated if these were not done, residents could develop pressure ulcer. When asked how often a Braden Scale Skin Assessment should be completed, Licensed Staff B stated Braden Scale Skin Assessment must be completed upon admission then weekly. Licensed Staff B stated if not done weekly, staff could miss important changes in risk factors that could be addressed to decrease likelihood of a resident developing a pressure ulcer. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 2/20/24 at 11:12 a.m., Licensed Staff C stated it was the facility ' s P&P with pressure ulcer prevention to turn and reposition residents every 2 hours, to provide good perineal care and to check and change incontinent residents every 2 hours and as needed. Licensed Staff C stated if these were not done, it meant facility policy was not followed which could result to worsened pressure injury, infection and pain. Licensed Staff C stated quality of life decreases when a resident was in pain. Licensed Staff C stated once a resident was deemed incontinent, a preventative treatment should be requested to the physician. Licensed Staff C stated if these were not done, resident could develop pressure ulcer. When asked how often a Braden Scale Skin Assessment should be completed, Licensed Staff C stated it should be completed upon admission then weekly. Licensed Staff C stated if this was not done weekly, staff may not be able to address risk factor changes that could lessen the likelihood of resident developing a pressure ulcer. During an interview on 2/20/24 at 12:06 p.m., Unlicensed Staff D stated for pressure ulcer prevention, it was facility ' s policy to ensure residents were turned and repositioned every 2 hours and to provide incontinence care every 2 hours or more often as needed. Unlicensed Staff D stated if these were not done, it could lead to the development of new skin issues or worsening of pressure ulcer. Unlicensed Staff D stated staff also provide a preventative treatment to apply on resident who were incontinent to prevent them from developing pressure sore. During an interview on 2/20/24 at 12:20 p.m., the MDS coordinator stated it was the facility ' s policy to turn and reposition residents every 2 hours, to provide incontinent care every 2 hours or more often as needed and to use barrier cream for incontinent residents per physician ' s order to decrease the risk of residents acquiring a pressure ulcer. When asked if Resident 1 had an individualized turning and repositioning schedule based on his risk factors, the MDS coordinator stated Resident 1 did not have an individualized turning and repositioning schedule based on his risk factor. The MDS coordinator verified Resident 1 pressure ulcer was acquired while he was at the facility. When asked when does staff conduct skin assessments, the MDS coordinator stated the Braden Scale Skin assessment was done upon admission and weekly for the next 3 weeks post admission per facility policy. The MDS coordinator stated staff should follow this and if this was not done, then the facility was not following the skin policy. The MDS coordinator stated if the Braden Scale Skin assessment was not done, there could be risk for staff to miss skin and risk changes, that if known, staff could implement interventions to decrease the risk of resident developing a pressure ulcer. The MDS coordinator stated skin issues could develop and worsen if not being assessed regularly. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 2/20/24 at 12:40 p.m., the Director of Nursing (DON) stated it was the facility ' s policy to turn and reposition residents every 2 hours or more frequently as needed, to provide incontinent care to residents every 2 hours and more often as needed to decrease the risk of residents developing a pressure ulcer. The DON stated Resident 1 ' s skin was intact upon admission, however on 1/15/24, it was noted he developed a pressure ulcer on his left buttock up to his tail bone. Per the Interdisciplinary Team (IDT, a group of dedicated healthcare professionals who work together to provide you with the care you need, when you need it) skin review note dated 1/22/24, the Stage 2 PU on Resident 1 ' s left buttock size was 5.0 by 1.0 centimeter (cm, a unit of measure). DON stated Resident 1 ' s pressure sore developed in the facility. The DON was unable to determine if Resident 1 ' s pressures ulcer was avoidable or unavoidable. When asked when staff conducts skin assessments, the DON stated the Braden Scale Skin Assessments was done upon admission then weekly for the next 4 weeks per facility policy. The DON stated the Braden Scale Skin Assessment was important because it identifies a residents ' risk for developing pressure sore. The DON stated if the Braden Scale Skin Assessment was not done per facility policy, it could lead to missing other skin issues. The DON stated it could also lead to missed related risk factors that predispose residents to pressure sore development. During an interview on 2/23/24 at 10:01 a.m., a request was made to see Resident 1 ' s daily skin assessment. The DON was only able to provide 1 skin evaluation form dated 1/15/24 and 5 shower skin sheets dated 1/3/24, 1/6/24, 1/10/24, 1/17/24 and 1/20/24. The shower skin sheet on 1/17 and 1/20 did not indicate Resident 1 had a pressure ulcer on his left buttocks. A review of the facility ' s policy and procedure (P&P) titled Prevention of Pressure Injuries, revised 4/2020, the P&P indicated to assess the resident on admission for existing pressure injury risk factors and to repeat risk assessments weekly and upon any changes in condition .inspect the skin on a daily basis when performing or assisting with personal care or activities of daily living .use a barrier product to protect skin from moisture .reposition all residents with or at risk of pressure injuries on an individualized schedule . frequency for repositioning based on residents risk factors and current clinical practice. Based on interviews and record reviews, the facility failed to ensure one out of two sampled resident (Resident 1) did not develop a pressure ulcer when the facility did not follow their policy and procedure for prevention of pressure injuries such as inspecting the skin daily when performing or assisting with personal care or activities of daily living (ADL, tasks of everyday life), did not continually evaluate Resident 1's potential for skin breakdown per physician's order and request a preventative treatment prescribed by the physician once Resident 1 became incontinent of both bladder (the ability to control on when to empty the urine)and bowel function (the ability to control when to have a bowel movement). These failures resulted to Resident 1 acquiring a stage 2 pressure ulcer (PU, a shallow open ulcer with a red or pink wound bed, caused when an area of skin is placed under pressure). Findings: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 1 face sheet (demographics) indicated he was admitted on [DATE] with a diagnoses of Essential Hypertension (HTN, high blood pressure), Hyperlipidemia (HLP, an elevated level of lipids like cholesterol and triglycerides in your blood) and Type 2 Diabetes Mellitus (DM, a disease that occurs when your blood glucose, also called blood sugar, is too high). His Minimum Data Sheet Assessment (MDS, a federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes) dated 1/23/24 Brief Interview for Mental Status (BIMS, a mandatory tool used to screen and identify the cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) condition of residents, indicated Resident 1 had a short term and long-term memory impairment. Resident 1's MDS assessment also indicated he was always incontinent of both bladder and bowel. His MDS assessment also indicated Resident 1 had 1 unhealed pressure ulcer when he was discharged at the facility on 1/23/24. Resident 1's admission note dated 1/2/24 22:34 indicated the admission skin assessment was done, and the coccyx (tailbone) and bony prominences (areas where bones are close to the surface and areas that are under the most pressure are at greatest risk for developing pressure sores) were intact. His skin Interdisciplinary Team (IDT, professional disciplines, as appropriate, will work together to provide the greatest benefit for the resident) note dated 1/22/24 13:58 indicated Resident 1 was noted with a Stage 2 PU on his left buttock. A review of Resident 1's PO indicated there was no order for preventive treatment once Resident 1 became incontinent of bowel and bladder function. Further review of Resident 1's Physician Order (PO, the instruction the physician had written for a resident's treatment) dated 1/2/24, indicated to complete the Braden Scale assessment (a standardized, evidence-based assessment tool commonly used in health care to assess and document a patient's risk for developing pressure ulcer) upon admission and then weekly for the next 4 weeks. There was only 1 Braden Scale Skin Assessment completed dated 1/3/24, the score was 17, indicating Resident 1 had a mild risk for developing pressure ulcer. As per Braden Scale Skin assessment dated [DATE], Resident 1's skin was occasionally moist, walks occasionally during the day but for very short distance, had slight limited ability to change and control body position, had inadequate food intake, and issue with friction and shear during movement in bed or chair. There were no further Braden Scale Skin Assessment completed after 1/3/24. A review of Resident 1's ADL charting did not indicate he was being offered toileting or incontinence care every 2 hours. There were no documentations provided to indicate Resident 1 was being turned and repositioned every 2 hours. During an interview on 2/20/24 at 10:12 a.m., Unlicensed Staff A stated it was the facility's policy to ensure residents were turned and repositioned every 2 hours to offload weight and to check and change incontinent residents every 2 hours or more often as needed. Unlicensed Staff A stated staff would also apply a barrier cream on residents who were incontinent. Unlicensed Staff A stated not doing these could result to development of pressure sores, open wounds, pain and infections. During an interview on 2/20/24 at 10:30 a.m., Licensed Staff B stated it was the facility's P&P with pressure sore prevention to turn and reposition residents every 2 hours as needed and as tolerated and to check and change incontinent residents every 2 hours or more often as needed. Licensed Staff B stated residents who were incontinent were more prone to develop pressure ulcer so it was important to initiate a preventive treatment per physician's order. Licensed Staff B stated if these were not done, residents could develop pressure ulcer. When asked how often a Braden Scale Skin Assessment should be completed, Licensed Staff B stated Braden Scale Skin Assessment must be completed upon admission then weekly. Licensed Staff B stated if not done weekly, staff could miss important changes in risk factors that could be addressed to decrease likelihood of a resident developing a pressure ulcer. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 2/20/24 at 11:12 a.m., Licensed Staff C stated it was the facility's P&P with pressure ulcer prevention to turn and reposition residents every 2 hours, to provide good perineal care and to check and change incontinent residents every 2 hours and as needed. Licensed Staff C stated if these were not done, it meant facility policy was not followed which could result to worsened pressure injury, infection and pain. Licensed Staff C stated quality of life decreases when a resident was in pain. Licensed Staff C stated once a resident was deemed incontinent, a preventative treatment should be requested to the physician. Licensed Staff C stated if these were not done, resident could develop pressure ulcer. When asked how often a Braden Scale Skin Assessment should be completed, Licensed Staff C stated it should be completed upon admission then weekly. Licensed Staff C stated if this was not done weekly, staff may not be able to address risk factor changes that could lessen the likelihood of resident developing a pressure ulcer. During an interview on 2/20/24 at 12:06 p.m., Unlicensed Staff D stated for pressure ulcer prevention, it was facility's policy to ensure residents were turned and repositioned every 2 hours and to provide incontinence care every 2 hours or more often as needed. Unlicensed Staff D stated if these were not done, it could lead to the development of new skin issues or worsening of pressure ulcer. Unlicensed Staff D stated staff also provide a preventative treatment to apply on resident who were incontinent to prevent them from developing pressure sore. During an interview on 2/20/24 at 12:20 p.m., the MDS coordinator stated it was the facility's policy to turn and reposition residents every 2 hours, to provide incontinent care every 2 hours or more often as needed and to use barrier cream for incontinent residents per physician's order to decrease the risk of residents acquiring a pressure ulcer. When asked if Resident 1 had an individualized turning and repositioning schedule based on his risk factors, the MDS coordinator stated Resident 1 did not have an individualized turning and repositioning schedule based on his risk factor. The MDS coordinator verified Resident 1 pressure ulcer was acquired while he was at the facility. When asked when does staff conduct skin assessments, the MDS coordinator stated the Braden Scale Skin assessment was done upon admission and weekly for the next 3 weeks post admission per facility policy. The MDS coordinator stated staff should follow this and if this was not done, then the facility was not following the skin policy. The MDS coordinator stated if the Braden Scale Skin assessment was not done, there could be risk for staff to miss skin and risk changes, that if known, staff could implement interventions to decrease the risk of resident developing a pressure ulcer. The MDS coordinator stated skin issues could develop and worsen if not being assessed regularly. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 2/20/24 at 12:40 p.m., the Director of Nursing (DON) stated it was the facility's policy to turn and reposition residents every 2 hours or more frequently as needed, to provide incontinent care to residents every 2 hours and more often as needed to decrease the risk of residents developing a pressure ulcer. The DON stated Resident 1's skin was intact upon admission, however on 1/15/24, it was noted he developed a pressure ulcer on his left buttock up to his tail bone. Per the Interdisciplinary Team (IDT, a group of dedicated healthcare professionals who work together to provide you with the care you need, when you need it) skin review note dated 1/22/24, the Stage 2 PU on Resident 1's left buttock size was 5.0 by 1.0 centimeter (cm, a unit of measure). DON stated Resident 1's pressure sore developed in the facility. The DON was unable to determine if Resident 1's pressures ulcer was avoidable or unavoidable. When asked when staff conducts skin assessments, the DON stated the Braden Scale Skin Assessments was done upon admission then weekly for the next 4 weeks per facility policy. The DON stated the Braden Scale Skin Assessment was important because it identifies a residents' risk for developing pressure sore. The DON stated if the Braden Scale Skin Assessment was not done per facility policy, it could lead to missing other skin issues. The DON stated it could also lead to missed related risk factors that predispose residents to pressure sore development. During an interview on 2/23/24 at 10:01 a.m., a request was made to see Resident 1's daily skin assessment. The DON was only able to provide 1 skin evaluation form dated 1/15/24 and 5 shower skin sheets dated 1/3/24, 1/6/24, 1/10/24, 1/17/24 and 1/20/24. The shower skin sheet on 1/17 and 1/20 did not indicate Resident 1 had a pressure ulcer on his left buttocks. A review of the facility's policy and procedure (P&P) titled Prevention of Pressure Injuries , revised 4/2020, the P&P indicated to assess the resident on admission for existing pressure injury risk factors and to repeat risk assessments weekly and upon any changes in condition .inspect the skin on a daily basis when performing or assisting with personal care or activities of daily living .use a barrier product to protect skin from moisture .reposition all residents with or at risk of pressure injuries on an individualized schedule . frequency for repositioning based on residents risk factors and current clinical practice.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46132 Based on interviews and record reviews, the facility failed to ensure nursing staff were competent and had skills to provide nursing and related services to assure resident safety when the nurses did not follow the facility ' s policy and procedure on narcotic (drug that causes stupor or insensibility) count reconciliation (physical inventory of all controlled substances), when nurses left the medicine cart (med cart) keys on top of the med cart unattended and the nurses did not know Baza Cream (an incontinent cream that contains zinc oxide, a medicated cream, ointment or paste that treats or prevents skin irritation) requires a Physician Order (PO, the instruction the physician had written for a patients ' treatment) prior to applying it on a resident skin. These failures were a safety risk that resulted in missing /unaccounted 3 tablets of narcotics (a medication that dulls the senses and treat pain) for one out of two sampled residents (Resident 2). These failures could lead to unauthorized access to the med cart, medication error (med error) and residents not receiving the correct treatment medication to address a skin issue. Findings: A review of resident 2 ' s face sheet (demographics) indicated she was admitted to the facility on [DATE] with a diagnoses of Parkinson ' s Disease (PD, a progressive disorder that affects the nervous system and the parts of the body controlled by the nerves), Dysphagia (difficulty swallowing) and Hyperlipidemia (HLP, an elevated level of lipids like cholesterol and triglycerides in your blood). Her Minimum Data Sheet Assessment (MDS, a federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes) dated 2/2/24 Brief Interview for Mental Status (BIMS, a mandatory tool used to screen and identify the cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) condition of residents, indicated Resident 2 had a short term and long-term memory impairment. A review of Resident 2 ' s PO indicated she had an order for a Percocet (a narcotic) 5 milligram (mg, a unit of measure) - 325 mg 1 tablet by mouth every 8 hours for pain management. A review of the letter addressed to the Department, dated 1/31/24 , indicated there were unexplained 3 missing tablets of Percocet 5 mg- 325 mg. During an interview on 2/23/24 at 10:01 a.m., the Director of Nursing (DON) stated based on her investigation, nobody could tell her where the missing Percocet went and her investigation did not provide an answer as to what happened in this situation. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/20/24 at 10:30 a.m. Licensed Staff B stated it was the facility ' s policy for nurses to reconcile narcotic count before the start and end of their shift to ensure narcotics count were accurate and to ensure there were no missing narcotics. When asked why staff need to do narcotic count reconciliation, Licensed Staff B stated it was done to prevent missing narcotics and to account for all narcotics. When asked what the risk were if a narcotic reconciliation was not done, Licensed Staff B stated it could result to medication errors, drug diversion and residents not receiving their pain medication. When asked where staff kept the med cart keys, Licensed Staff B stated med cart keys should be with the nurse at all times. When asked if it was ever okay to leave the med cart key on top of the med cart, unattended, Licensed Staff B stated no. Licensed Staff B stated med cart keys should be with the nurses even if they were on a break. When asked what the risk were if the med cart keys were left on top of the med cart, Licensed Staff B stated anybody could take the key and open the med cart. Licensed Staff B stated residents could also get into the med cart, take meds that was not meant for them that could affect them negatively. During an interview on 2/20/24 at 11:32 a.m., Licensed Staff C stated when she came on her morning shift on 1/22/24 and 1/23/24 the outgoing nurse from night shift never came to give her report nor do a narcotic count reconciliation. Licensed Staff C stated that on both days, she also did not complete a narcotic count reconciliation with the incoming nurse at the end of her shift. She stated she counted the narcotics by herself. When asked if the facility policy was followed when the narcotic count reconciliation with the incoming and outgoing nurse were not completed, Licensed Staff C answered no. When asked what the risk were of not completing the narcotic count reconciliation with the incoming and outgoing nurse before the start and the end of shift, Licensed Staff C stated, for the residents, there could be a risk for drug diversion, pain medication may not be available and resident would continue to be in pain which affects quality of life. Licensed Staff C stated she found the med cart key on top of the med cart unattended. Licensed Staff C stated on 1/22/24 and 1/23/24 the med cart keys were sitting at the top of the med cart unattended which was a no-no. Licensed Staff C stated it was always just sitting there when I come in. When asked what the risk were if med cart keys were left unattended at the top of a med cart, Licensed Staff C stated it was a safety issue as unauthorized person or a resident may get ahold of the key, open the med cart and take meds not meant for them. Licensed Staff C stated residents might get a hold of medications or take medications that would make them sick, could cause allergy, even death. Licensed Staff C stated not completing a narcotic count reconciliation per facility policy and not holding on to the med cart keys was a big safety and liability issue. During an interview on 2/20/24 at 12:13 p.m., Unlicensed Staff D stated she had seen nurses leave the med cart keys on top of the med cart sometimes. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/20/24 at 12:20 p.m., the Minimum Data Set (MDS) Coordinator stated it was the facility ' s policy to ensure narcotic count reconciliation was completed by 2 nurses at the beginning and end of shift. The MDS Coordinator stated if this was not done, it meant the facility policy was not followed. The MDS Coordinator stated this was unacceptable. When asked what the risk were if a narcotic count reconciliation was not completed by 2 nurses at the beginning and end of shift, she stated it was a safety issue, there could be a risk for discrepancy in narcotic count, narcotic could be stolen by anyone. The MDS coordinator stated the med cart keys should always be with the nurse and it was not acceptable to leave the med cart keys unattended on top of a med cart. The MDS Coordinator stated this was a safety issue. When asked what the risks were if the med cart keys were left on top of the med cart unattended, the MDS Coordinator stated it was a safety issue, anyone could take the key and gain access to the med cart. The MDS Coordinator stated only nurses were allowed access to med cart. During an interview on 2/23/24 at 10:01 a.m., the Director of Nursing (DON) stated it was the facility ' s policy to complete a narcotic count reconciliation between the incoming and outgoing nurses to verify narcotic counts were accurate and to prevent missing narcotics. The DON stated the facility policy was not followed if the nurses were not doing that. The DON stated not completing a narcotic count reconciliation between the incoming and outgoing nurses could result to narcotics missing and if unaccounted for, narcotic may not be available. When asked what the risks were for resident if a narcotic goes missing, the DON stated if there were no available narcotics, resident would continue to be in pain. When asked where nurses should keep the med cart keys, the DON stated med cart keys should be with the nurse at all times, even during break times. The DON also stated it was not okay to leave the med cart key unattended on top of the med cart. Leaving the med cart key unattended on top of the med cart meant the facility policy was not followed and it could result to unauthorized staff or residents gaining access to the med cart. The DON stated this was a safety issue. The DON stated staff were putting Baza cream on residents buttocks with every incontinent episodes. The DON stated Baza cream did not need an order because it was a nursing intervention. During an interview on 2/23/24 at 10:38 a.m., Licensed Staff E stated she was not sure if Baza cream had to have an order prior to applying on a resident skin. Licensed Staff E stated the facility had used Baza cream without a physician ' s order. Licensed Staff E stated the facility had no authorization to apply Baza cream on a resident ' s body without an order. Licensed Staff E stated putting Baza cream without a physician order could result to allergies, skin issue worsening and development of skin rashes. During an interview on 2/23/24 at 10:40 a.m., Licensed Staff F verified Baza cream had zinc oxide. Licensed Staff F stated the facility used Baza Incontinence cream for incontinence episode. Licensed Staff F stated, typically nurses at the facility do not ask the physician for a Baza cream order. During an interview on 2/23/24 at 11:07 a.m., the MDS Coordinator stated Baza cream should be ordered by the physician prior to applying on a resident ' s skin. The MDS Coordinator stated applying Baza cream without a physician order was beyond our scope of practice. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555727	A. Building B. Wing	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurel Creek Health Center	2800 Estates Drive Fairfield, CA 94533

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on 2/26/24 at 10:45 a.m., Licensed Staff G stated the facility policy was not followed when she did not complete a narcotic count reconciliation with another nurse before the start and end of her shift. Licensed Staff G stated not completing a narcotic count reconciliation could result to missing narcotics. Licensed Staff G stated the facility policy was also not followed when she left the med cart key unattended on top of the medication cart. Licensed Staff G stated not keeping the med cart key with her at all times could lead to unauthorized personnel or residents gaining access to the med cart. Licensed Staff G stated it was a safety issue. During a telephone interview on 2/26/24 at 3:00 p.m., the Pharmacist stated nurses should be completing a narcotic count reconciliation at the beginning and end of their shift. The Pharmacist stated not doing so could lead to missing narcotics. The Pharmacist stated staff should also be keeping the med cart keys with them and not leave the med cart key unattended on top of the med cart for safety purposes and to ensure only the nurses have access to the med cart. The Pharmacist stated Baza Incontinence cream is a medication that needs a physician ' s order before applying to a resident skin. The Pharmacist stated it should not be used without a physician ' s order. A review of the facility ' s policy and procedure (P&P) titled Controlled Substance Storage, revised 8/2014, the P&P indicated medications included in the Drug Enforcement Administration (DEA, the agency responsible for enforcing the controlled substances laws and regulations of the United States) classification as controlled substance are subject to special handling, storage, disposal and record keeping in the facility .if a key system is used, the medication nurse on duty maintains the possession of the key to the controlled substance storage areas .at each shift change, or when keys were transferred, a physical inventory of all controlled substances is conducted by 2 licensed nurses and is documented. A review og the facility ' s P&P titled Administering Medication revised 4/2019, the P&P indicated medications are administered in accordance with prescriber orders, including any required time frame. The P&P for Baza Cream use was requested but not provided. The DON stated the facility did not have a policy specific to Baza Cream usage. Based on interviews and record reviews, the facility failed to ensure nursing staff were competent and had skills to provide nursing and related services to assure resident safety when the nurses did not follow the facility's policy and procedure on narcotic (drug that causes stupor or insensibility) count reconciliation (physical inventory of all controlled substances), when nurses left the medicine cart (med cart) keys on top of the med cart unattended and the nurses did not know Baza Cream (an incontinent cream that contains zinc oxide, a medicated cream, ointment or paste that treats or prevents skin irritation) requires a Physician Order (PO, the instruction the physician had written for a patients' treatment) prior to applying it on a resident skin. These failures were a safety risk that resulted in missing /unaccounted 3 tablets of narcotics (a medication that dulls the senses and treat pain) for one out of two sampled residents (Resident 2). These failures could lead to unauthorized access to the med cart, medication error (med error) and residents not receiving the correct treatment medication to address a skin issue. Findings: (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of resident 2's face sheet (demographics) indicated she was admitted to the facility on [DATE] with a diagnoses of Parkinson's Disease (PD, a progressive disorder that affects the nervous system and the parts of the body controlled by the nerves), Dysphagia (difficulty swallowing) and Hyperlipidemia (HLP, an elevated level of lipids like cholesterol and triglycerides in your blood). Her Minimum Data Sheet Assessment (MDS, a federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes) dated 2/2/24 Brief Interview for Mental Status (BIMS, a mandatory tool used to screen and identify the cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) condition of residents, indicated Resident 2 had a short term and long-term memory impairment. A review of Resident 2's PO indicated she had an order for a Percocet (a narcotic) 5 milligram (mg, a unit of measure) - 325 mg 1 tablet by mouth every 8 hours for pain management. A review of the letter addressed to the Department, dated 1/31/24 , indicated there were unexplained 3 missing tablets of Percocet 5 mg- 325 mg. During an interview on 2/23/24 at 10:01 a.m., the Director of Nursing (DON) stated based on her investigation, nobody could tell her where the missing Percocet went and her investigation did not provide an answer as to what happened in this situation. During an interview on 2/20/24 at 10:30 a.m. Licensed Staff B stated it was the facility's policy for nurses to reconcile narcotic count before the start and end of their shift to ensure narcotics count were accurate and to ensure there were no missing narcotics. When asked why staff need to do narcotic count reconciliation, Licensed Staff B stated it was done to prevent missing narcotics and to account for all narcotics. When asked what the risk were if a narcotic reconciliation was not done, Licensed Staff B stated it could result to medication errors, drug diversion and residents not receiving their pain medication. When asked where staff kept the med cart keys, Licensed Staff B stated med cart keys should be with the nurse at all times. When asked if it was ever okay to leave the med cart key on top of the med cart, unattended, Licensed Staff B stated no. Licensed Staff B stated med cart keys should be with the nurses even if they were on a break. When asked what the risk were if the med cart keys were left on top of the med cart, Licensed Staff B stated anybody could take the key and open the med cart. Licensed Staff B stated residents could also get into the med cart, take meds that was not meant for them that could affect them negatively. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/20/24 at 11:32 a.m., Licensed Staff C stated when she came on her morning shift on 1/22/24 and 1/23/24 the outgoing nurse from night shift never came to give her report nor do a narcotic count reconciliation. Licensed Staff C stated that on both days, she also did not complete a narcotic count reconciliation with the incoming nurse at the end of her shift. She stated she counted the narcotics by herself. When asked if the facility policy was followed when the narcotic count reconciliation with the incoming and outgoing nurse were not completed, Licensed Staff C answered no. When asked what the risk were of not completing the narcotic count reconciliation with the incoming and outgoing nurse before the start and the end of shift, Licensed Staff C stated, for the residents, there could be a risk for drug diversion, pain medication may not be available and resident would continue to be in pain which affects quality of life. Licensed Staff C stated she found the med cart key on top of the med cart unattended. Licensed Staff C stated on 1/22/24 and 1/23/24 the med cart keys were sitting at the top of the med cart unattended which was a no-no . Licensed Staff C stated it was always just sitting there when I come in . When asked what the risk were if med cart keys were left unattended at the top of a med cart, Licensed Staff C stated it was a safety issue as unauthorized person or a resident may get ahold of the key, open the med cart and take meds not meant for them. Licensed Staff C stated residents might get a hold of medications or take medications that would make them sick, could cause allergy, even death. Licensed Staff C stated not completing a narcotic count reconciliation per facility policy and not holding on to the med cart keys was a big safety and liability issue. During an interview on 2/20/24 at 12:13 p.m., Unlicensed Staff D stated she had seen nurses leave the med cart keys on top of the med cart sometimes. During an interview on 2/20/24 at 12:20 p.m., the Minimum Data Set (MDS) Coordinator stated it was the facility's policy to ensure narcotic count reconciliation was completed by 2 nurses at the beginning and end of shift. The MDS Coordinator stated if this was not done, it meant the facility policy was not followed. The MDS Coordinator stated this was unacceptable. When asked what the risk were if a narcotic count reconciliation was not completed by 2 nurses at the beginning and end of shift, she stated it was a safety issue, there could be a risk for discrepancy in narcotic count, narcotic could be stolen by anyone. The MDS coordinator stated the med cart keys should always be with the nurse and it was not acceptable to leave the med cart keys unattended on top of a med cart. The MDS Coordinator stated this was a safety issue. When asked what the risks were if the med cart keys were left on top of the med cart unattended, the MDS Coordinator stated it was a safety issue, anyone could take the key and gain access to the med cart. The MDS Coordinator stated only nurses were allowed access to med cart. (continued on next page)

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