STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555771	A. Building B. Wing	04/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookdale Riverwalk Snf (CA)	350 Calloway Drive, Building C Bakersfield, CA 93312

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47095 Based on interview and record review, the facility failed to ensure medications were administered according to the physician order(s) for one of four sampled residents (Resident 1) when: 1. Resident 1's Sodium Chloride (salt-based solution to provide hydration) Intravenous (IV-medication administration route into a vein of a person's body) solution was not administered as ordered. 2. Resident 1's Amiodarone (antiarrhythmic medication-prevents and treats a fast or irregular heartbeat [arrhythmia] by slowing down overactive electric signals in the heart, which stabilizes heart rate and rhythm [strong sound]) was not administered as ordered. These failures had the potential to cause adverse health outcomes. Findings: 1. During an interview and record review on 3/18/24 at 4:58 p.m. with Clinical Nurse Specialist (CNS), Resident 1's Medical Record (MR) was reviewed, the MR indicated the following: Physician Order [PO] dated 11/2/23 indicated, Start IV fluids Now: IV NS[normal saline] 0.9% @[at] 75 cc [cubic centimeter]/hr [hour] x 2 Liters (2 Liters @ 75 cc/hr). CNS stated Resident 1 had a physician order for hydration continuously for 3 days. Resident 1's Medication Administration Record (MAR) dated, [DATE] , indicated, blanks on 11/3/23 and 11/4/23 night shift. CNS stated Resident 1's MAR were blanks on 11/3/23 and 11/4/23, blanks meant not documented not done. 2. During a concurrent interview and record review on 4/23/24 at 1:45 p.m. with Director of Nursing (DON), Resident 1's Medical Record (MR) was reviewed and indicated the following: Resident 1's PO dated 10/4/23 indicated, Amiodarone. Oral Tablet 200 MG [milligram] Give 1 tablet by mouth one time a day. DON stated the start date was 10/5/23 with no end date. Resident 1's MAR dated, [DATE] , indicated Amiodarone. Oral Tablet 200 MG. Give 1 tablet by mouth one time a day. Start Date 10/05/2023 0900 [9 a.m.]. DON stated on 11/16/23 at 9 a.m. Amiodarone 200 mg was administered to Resident 1. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 1's PO dated 11/16/23 indicated, Amiodarone. Oral Tablet 100 MG[milligram]. Medication Class: ANTIARRHYTHMICS. Frequency: two times a day Schedule Type: Everyday Facility Time Code: 0900/1700[5 p.m.]. Start Date: 11/16/2023. Resident 1's MAR dated, [DATE] , indicated Amiodarone. Oral Tablet 100 MG. Give 100 mg by mouth two times a day. Start Date 11/16/2023 1700 D/C Date 02/19/2024 1637. 1700 [medication administration]. DON stated on 11/16/23 at 5 p.m. Amiodarone 100 mg was administered to Resident 1. DON stated on 11/16/23 at 5 p.m. Resident 1 had an order of Amiodarone for 200 mg once daily (10/5/23), since Resident 1 was having nausea and vomiting the physician ordered (11/16/23) to split the dosage of Amiodarone to 100 mg twice daily. DON stated the Amiodarone 100 mg should have been started the next day (11/17/23) since Resident 1 had received her 9 a.m. scheduled dose of Amiodarone 200 mg oral daily. Resident 1's Progress Note (PN) dated 11/17/23 at 5:33 p.m. indicated, Spoke with NP[Nurse Practitioner-an advanced practice nurse]. 11/16/23 in AM Amiodarone 200 mg 1 tablet one time a day and in PM shift Amiodarone 100 mg two times a day was given. Reviewed orders with NP and concluded that in total 300 mg was given, therefore a medication error occurred. An adverse effect of residents qt interval [electrical conduction of the heart function in a graphical wave form obtained from an electrocardiogram-(EKG- a heart function diagnostic exam)] could change EKG results. DON stated on 11/16/23 Resident 1 was administered Amiodarone 300 mg instead of 200 mg total dosage which should not have happened and had the potential to cause Resident 1 side effects of heart rate changes, nausea and vomiting. DON stated the nursing standards of medication administration included The right patient, the right dose and right frequency and she [nurse] did not do that. Requested the facility's medication administration P&P for nursing services on 3/18/24, 4/19/23 and 4/23/24 and no policy was provided.