STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555776	A. Building B. Wing	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gridley Post Acute	246 Spruce Street Gridley, CA 95948

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50363 Based on interview and record review, the facility failed to inform one of three sampled residents (Resident 1) of the risks and benefits of proposed care, treatment, and treatment alternatives in a language she could understand (Spanish) prior to starting a psychotropic (drugs that affect a person's mental state) medication. This failure denied Resident 1's responsible party (RP) her right to participate in Resident 1's treatment decisions and had the potential to affect Resident 1's functional status, rehabilitation and restorative potential, ability to participate in activities, cognitive status, and psychosocial status. Findings: During a record review of Resident 1's admission record, indicated Resident 1 was admitted on [DATE] with diagnoses that included dementia (a decline in mental abilities that affect daily life), glaucoma (chronic eye disease that can cause vision loss or blindness), dysphagia (difficulty swallowing), and type 2 diabetes (body cannot produce enough insulin). Document indicated Resident 1's primary language was Spanish, and her RP's primary language was Spanish. During a record review of document titled Minimum Data Set (MDS) Section C, Resident 1's Brief Interview of Mental Status (BIMS) score was 8, indicated moderate cognitive impairment. During a record review of facility policy titled Informed Consent Verification (undated), indicated facility shall verify that informed consent has been obtained by the physician before a psychotherapeutic medication is administered. The policy also indicated the facility needed to obtain indication for use from the physician. The policy also indicated a printed or electronic version of the informed consent would be included in resident's medical record. During a record review of Resident 1's Medication Administration Record (MAR) September 2024, October 2024, and November 2024, indicated Resident 1 received Rexulti 2 mg by mouth once daily from 9/6/2024 - 11/8/2024 for dementia as evidenced by psychotic behaviors. (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a website review on www.dailymed.nlm.nih.gov/dailymed/ (undated), Rexulti had a boxed warning (the strongest warning that the Federal Drug Administration (FDA) required, and signified medical studies indicated drug carried a significant risk of serious or life-threatening adverse effects) and indicated increased mortality in elderly patients with dementia-related psychosis. Website further indicated medical studies found that Rexulti is not approved for the treatment of patients with dementia-related psychosis .due to increased risk of death [due to] heart failure, sudden death, and pneumonia. During a record review of document titled Discontinued Physician Orders (undated), indicated Medical Director (MD) started Resident 1 on Rexulti 2 milligrams (mg) by mouth once daily on 9/6/2024. MD did not document behaviors that indicated the need for the medication order. MD discontinued the medication on 11/8/2024 with no indication for the discontinuation of the order. During a concurrent interview with Director of Nursing (DON) on 12/31/2024 at 11:56 am, DON stated facility could not locate informed consent for MD order of Rexulti 2 mg by mouth once daily. DON confirmed the informed consent was not scanned into Resident 1's chart. The DON stated Resident 1 did really well on the medication and staff saw good results when Resident 1 took the medication. The DON stated Resident 1's responsible party requested facility discontinue medication order. DON stated MD was notified and confirmed medication order was discontinued. During a concurrent interview with Administrator (Admin) on 12/31/2024 at 12:10 pm, Admin confirmed facility could not locate Resident 1's informed consent for MD order of Rexulti 2 mg by mouth once daily. Admin stated informed consent facility process included a signature by responsible party or resident and scanned into resident's chart. Admin confirmed informed consent was not scanned into Resident 1's chart. During a concurrent interview on 1/2/2025 at 11:30 am with Resident 1's physician (MD), MD stated he prescribed Rexulti 2 mg by mouth once daily for Resident 1 due to some aggression issues and agitation problems towards staff and other residents. MD could not recall when the order was started, the timeframe Resident 1 took the medication, nor when the order was discontinued. MD stated he did not observe Resident 1's behavior prior to the medication being prescribed or Resident 1's behavior when she took the medication. MD stated he could not remember if he signed an informed consent for Resident 1 to start the medication. MD stated I don't know. I can't remember. During a concurrent interview with Responsible Party (RP) on 1/8/2025 at 10:25 am, RP stated she never spoke to the MD before Resident 1 started Rexuli 2 mg by mouth once daily. RP stated only person she spoke to at facility regarding the medication was a Certified Nursing Assistant (CNA). RP stated during a conversation with the CNA, she agreed to start the medication. RP stated the risks and benefits were not explained to her by the MD. RP stated she had no idea how Resident 1 did on the medication due to no communication from facility. RP stated she did not like that Resident 1 had a flat expression on the medication, and requested it discontinued. RP stated she made this request through a Spanish-speaking CNA. During a concurrent interview with DON on 1/16/2025 at 10:00 am, DON stated she heard about Rexulti and thought it would be a good medication for Resident 1. DON stated she contacted MD and requested an order. DON re-confirmed an informed consent could not be located for Resident 1.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50363 Based on interview, and record review, the Medical Director (MD) failed to provide progress notes for one of three sampled residents (Resident 1) that reflected a review of total resident care, current condition (including medications and treatments), and MD decisions about the continued appropriateness of a medical regimen. The facility also failed to work with the MD or seek alternate MD participation to ensure Resident 1 received appropriate care and treatment. This failure had the potential to result in miscommunication of medical diagnosis, treatment, unclear and/or missing direct care staff expectations for Resident 1. Findings: During a record review of Resident 1's admission record, indicated Resident 1 was admitted on [DATE] with diagnoses that included dementia (a decline in mental abilities that affect daily life), glaucoma (chronic eye disease that can cause vision loss or blindness), dysphagia (difficulty swallowing), and type 2 diabetes (body cannot produce enough insulin). Document indicated Resident 1's primary language was Spanish, and her RP's primary language was Spanish. During a record review of document titled Minimum Data Set (MDS) Section C, Resident 1's Brief Interview of Mental Status (BIMS) score was 8, indicated moderate cognitive impairment. During a record review of document titled Discontinued Physician Orders, indicated Medical Director (MD) started Resident 1 on Rexulti 2 milligrams (mg) by mouth once daily on 9/6/2024. MD did not document behaviors that indicated the need for the medication order. MD discontinued the medication on 11/8/2024 with no indication for the discontinuation of the order. During a record review of Resident 1's Medication Administration Record (MAR) September 2024, October 2024, and November 2024, indicated Resident 1 received Rexulti 2 mg by mouth once daily from 9/6/2024 - 11/8/2024 for dementia as evidenced by psychotic behaviors. During a record review of document titled Physician Note September 2024, MD indicated no new behaviors, though continues to have occasional verbal outbursts and yelling at staff. MD did not document the order for Resident 1 to start Rexulti 2 mg by mouth once daily on 9/6/2024. MD did not document Resident 1 received Rexulti 2 mg by mouth once daily from 9/6/2024 - 9/30/2024. MD indicated no changes to medications this month. During a record review of document titled Physician Note October 2024, MD indicated no new behaviors documented. MD did not document that Resident 1 received Rexulti 2 mg by mouth once daily for the entire month. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of document titled Physician Note November 2024, MD indicated resident noted to be pinching other residents and making false accusations .some bruising noted on right forearm. Resident denies any aggressive behaviors. MD did not document that Resident 1 received Rexulti 2 mg by mouth once daily from 11/1/2024 - 11/8/2024. MD indicated in document no changes to medications this month. During an interview on 1/2/2025 at 11:30 am with MD, MD stated he prescribed Rexulti 2 mg by mouth once daily for Resident 1 due to some aggression issues and agitation problems towards staff and other residents. MD could not recall when the order was started, the timeframe Resident 1 took the medication, nor when the order was discontinued. MD stated he did not observe Resident 1's behavior prior to the medication being prescribed or Resident 1's behavior when she took the medication. MD stated he could not remember if he signed an informed consent for Resident 1 to start the medication. MD stated I don't know. I can't remember.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50363 Based on interview, and record review, the facility failed to adequately document the necessity of a psychotropic medication for one of three sampled residents' (Resident 1) with resident-centered indications for use and monitoring for adverse side effect while on Rexulti (an atypical antipsychotic medication). This failure had the potential to result in Resident 1 not maintaining her highest practicable mental, physical, and psychosocial well-being and put Resident 1 at a high risk for physical harm due to adverse consequences. Findings: During a record review of Resident 1's admission record, indicated Resident 1 was admitted on [DATE] with diagnoses that included dementia (a decline in mental abilities that affect daily life), glaucoma (chronic eye disease that can cause vision loss or blindness), dysphagia (difficulty swallowing), and type 2 diabetes (body cannot produce enough insulin). Document indicated Resident 1's primary language was Spanish, and her responsible party (RP)'s primary language was Spanish. During a record review of document titled Minimum Data Set (MDS) Section C, Resident 1's Brief Interview of Mental Status (BIMS) score was 8, indicated moderate cognitive impairment. During a record review of document titled Discontinued Physician Orders (undated), indicated Medical Director (MD) started Resident 1 on Rexulti 2 milligrams (mg) by mouth once daily on 9/6/2024. MD did not document behaviors that indicated the need for the medication order. MD discontinued the medication on 11/8/2024 with no indication for the discontinuation of the order. During a record review of Resident 1's Medication Administration Record (MAR) September 2024, October 2024 and November 2024, indicated Resident 1 received Rexulti 2 mg by mouth once daily from 9/6/2024 - 11/8/2024 for dementia as evidenced by psychotic behaviors. During a website review on www.dailymed.nlm.nih.gov/dailymed/ (undated), Rexulti had a boxed warning (the strongest warning that the Federal Drug Administration (FDA) required, and signified medical studies indicated drug carried a significant risk of serious or life-threatening adverse effects) and indicated increased mortality in elderly patients with dementia-related psychosis. Website further indicated medical studies found that Rexulti is not approved for the treatment of patients with dementia-related psychosis .due to increased risk of death [due to] heart failure, sudden death, and pneumonia. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of facility policy titled Psychotropic Medication Use 2001 MED-PASS, indicated residents who have not used psychotropic medications are not prescribed or given these medications unless the medication is determined to be necessary to treat a specific condition that is diagnosed and documented in the medical record. Furthermore, the document indicated a comprehensive assessment of the resident needed to be performed prior to describing a psychotropic medication. This includes evaluation of the resident's signs and symptoms in order to identify underlying causes. Document also indicated when determining whether to initiate, modify, or discontinue medication therapy, the [Interdisciplinary Team IDT] conducts an evaluation of the resident to determine other causes for symptoms, signs and symptoms that were clinically significant to warrant medication therapy, and the actual or intended benefit of the medication is understood by the resident/responsible party (RP). During an interview with Director of Nursing (DON) on 12/31/2024 at 11:56 am, DON stated facility spoke with RP prior to starting Resident 1 on Rexuli 2 mg by mouth once daily and RP agreed to medication. DON confirmed facility could not locate informed consent for MD order of Rexulti 2 mg by mouth once daily. DON stated Resident 1 did really well on medication and staff saw good results when Resident 1 took the medication. DON stated Resident 1's responsible party requested facility discontinue medication order in November 2024. DON stated MD was notified and confirmed medication order was discontinued on 11/8/2024. During an interview on 1/2/2025 at 11:30 am with MD, MD stated he prescribed Rexulti 2 mg by mouth once daily for Resident 1 due to some aggression issues and agitation problems towards staff and other residents. MD could not recall when the order was started, the timeframe Resident 1 took the medication, nor when the order was discontinued. MD stated he did not observe Resident 1's behavior prior to the medication being prescribed or Resident 1's behavior when she took the medication. MD stated he could not remember if he signed an informed consent for Resident 1 to start the medication. MD stated I'm sure I did. Usually, staff will put it in my box and sign it. I don't know. I can't remember. MD stated he prescribed the medication after facility contacted him and specifically requested a prescription for Rexulti for Resident 1. MD was unaware Rexulti had a boxed warning and could have caused adverse consequences for Resident 1. During an interview with Responsible Party (RP) on 1/8/2025 at 10:25 am, RP stated she never spoke to the MD before Resident 1 started Rexuli 2 mg by mouth once daily. RP stated only person she spoke to at facility regarding the medication was a Certified Nursing Assistant (CNA). RP stated she was never updated by facility or MD how Resident 1 did on the medication. RP stated risks and benefits were not explained to her by the MD. RP stated she had no idea how Resident 1 did on the medication due to no communication from facility. RP stated she went to facility in early November 2024 to retrieve laundry from Resident 1 and a housekeeper that spoke Spanish told her how Resident 1 did on the medication and how her behaviors had changed. RP stated she did not like that Resident 1 had a flat expression on the medication, and requested it discontinued. RP stated she made this request through a Spanish-speaking CNA. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/16/2025 at 10:00 am, the Director of Nursing (DON) stated the clinical indication for Rexulti 2 mg by mouth once daily for Resident 1 was dementia with behaviors, like yelling at staff. DON stated she entered the order for Rexulti 2 mg by mouth once daily after speaking with MD. DON stated, I heard it was a new medication for dementia and I thought [Resident 1] would do well on it. DON stated facility did not monitor Resident 1 per facility policy for at least three days when Resident 1 started the medication. DON stated she missed entering the monitoring parameters into Resident 1's MAR for behaviors and side effects of the medication. DON confirmed facility did not monitor Resident 1 on Rexulti 2 mg by mouth once daily. DON stated facility IDT did not determine what behaviors to monitor. DON stated she did not communicate relevant information regarding medication monitoring for Resident 1 to other staff members. DON stated facility did not assess if the medication was effective. DON stated facility did not attempt to reduce the medication. DON stated she did not communicate Resident 1's behavior to MD when she requested the medication for Resident 1.