STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555853	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Veterans Home of California - Barstow	100 East Veterans Parkway Barstow, CA 92311

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. 49613 Based on interview and record review, the facility failed to document non-pharmacological interventions for five of five sampled residents (Residents 1, 21, 24, 25, and 31) on psychotropic (affecting brain activities associated with mental processes and behavior) medications. This failure had the potential for residents to receive unnecessary psychotropic medications which can lead to side effects, such as sedation and falls. Findings: 1. A review of Resident 1's medical records indicated the following physician's orders: a. Alprazolam (generic for Xanax, a medication for anxiety) 0.5 milligrams (mg) OD (orally disintegrating, dissolves in the mouth), take one tablet by mouth and allow to dissolve daily for anxiety, manifested by mood changes, irritability, negative thoughts. Monitor for behavior and side effects every shift, dated 2/13/25; b. Bupropion (generic for Wellbutrin XL, extended release, a medication for depression) 150 mg, take one tablet by mouth daily for depression disorder m/b (manifested by) verbalization of hopelessness and sadness. Monitor for behaviors and side effects every shift, dated 12/10/24; and c. Olanzapine (generic for Zyprexa, a medication to treat psychiatric conditions) 5 mg, take one tablet by mouth daily at bedtime for schizophrenia (a psychiatric condition) m/b hallucinations and delusions. Monitor side effects and behaviors every shift, dated 12/10/24. A review of Resident 1's medical records included March 2025 Behavior Monitoring Records (BMR) for alprazolam, bupropion, and olanzapine. The following behaviors were documented for alprazolam: one episode of irritability on 3/3/2025 and one episode of mood changes on 3/3/25. The following behaviors were documented for bupropion: one episode of sadness on 3/20/25. The following behaviors were documented for olanzapine: one episode of delusions on 3/30/25. The medical record also included a blank form, Resident 1's March 2025 Non-Pharmacological Intervention (NPI) Flow Sheet for Psychotropic Medication (NPI Flow Sheet). (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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 1's medical records included a care plan for depression, created 7/13/24. The depression care plan intervention, updated 2/6/25, indicated Provide Non-Drug Interventions and document on non medication intervention sheet, when resident behavior occurs. The care plan interventions, updated 7/13/24, also indicated Use Non-Drug Interventions or Approaches to Address Behaviors in Addition to Ordered Medications. A review of Resident 1's medical records included a care plan for schizophrenia, created 7/13/24. The schizophrenia care plan intervention, updated 7/13/24, indicated Use Non-Drug Interventions or Approaches to Address Behaviors in Addition to Ordered Medications. During a concurrent interview and record review on 5/1/25 at 2:57 p.m. with the Director of Nursing (DON) 1, Resident 1's March 2025 BMRs and March 2025 NPI Flow Sheet were reviewed. DON 1 acknowledged the medical record indicated no NPI were provided to Resident 1 in March 2025 as required. 2. A review of Resident 24's medical records indicated the following physician's orders: a. Fluoxetine (generic for Prozac, a medication for depression) 20 mg, take one capsule by mouth daily for depressive disorder, dated 10/15/24; and b. Olanzapine 5 mg, take one tablet by mouth daily for depressive disorder with anxiety, dated 10/15/24. A review of Resident 24's medical records included March 2025 BMR for fluoxetine and olanzapine. The following behaviors were documented for fluoxetine: one episode of anxiousness on 3/12/25 and 3/26/25. The following behaviors were documented for olanzapine: one episode of anxiousness on 3/12/25. The medical record also included a blank form, Resident 24's March 2025 NPI Flow Sheet. A review of Resident 24's medical records included a care plan for mood disorder manifested by anxiousness, created 8/25/24. The anxiousness care plan intervention, updated 2/6/25, indicated Provide Non-Drug Interventions and document on non medication intervention sheet, when resident behavior occurs. A review of Resident 24's medical records included a care plan for depressive disorder, created 8/25/2024. The depression care plan intervention, updated 2/6/25, indicated Provide Non-Drug Interventions and document on non medication intervention sheet, when resident behavior occurs. During a concurrent interview and record review on 5/1/25 at 2:57 p.m. with DON 1, Resident 24's March 2025 BMRs and March 2025 NPI Flow Sheet were reviewed. DON 1 acknowledged the medical record indicated no NPI were provided to Resident 24 in March 2025 as required. 3. A review of Resident 25's medical records indicated the following physician's orders: a. Escitalopram (generic for Celexa, a medication for depression) 10 mg, take one tablet by mouth daily for depression m/b verbalizations of sadness, dated 5/30/24; b. Lorazepam (generic for Ativan, a medication for anxiety) 0.5 mg, take one tablet by mouth daily for anxiety disorder, m/b agitation and irritability, dated 1/28/25; and (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. Quetiapine (generic for Seroquel, a medication for psychiatric conditions) 50 mg, take one tablet by mouth daily at bedtime for depressive disorder with psychosis m/b hallucinations and angry outbursts, dated 5/30/24. A review of Resident 25's medical records included March 2025 BMR for escitalopram, lorazepam, and quetiapine. The following behaviors were documented for lorazepam: two episodes of agitation on 3/25/25, and one episode of irritability on 3/3/25, 3/28/25, and 3/30/25. The following behaviors were documented for quetiapine: one episode of angry outbursts on 3/25/25. The medical record also included a blank form, Resident 25's March 2025 NPI Flow Sheet. A review of Resident 25's medical records included a care plan for anxiety disorder, created 4/18/24. The anxiety care plan intervention, updated 2/6/25, indicated Provide Non-Drug Interventions and document on non medication intervention sheet, when resident behavior occurs. The care plan interventions, updated 4/18/24, also indicated Use Non-Drug Interventions or Approaches to Address Behaviors in Addition to Ordered Medications. During a concurrent interview and record review on 5/1/25 at 2:57 p.m. with DON 1, Resident 25's March 2025 BMRs and March 2025 NPI Flow Sheet were reviewed. DON 1 acknowledged the medical record indicated no NPI were provided to Resident 25 in March 2025 as required. 51705 4. A review of Resident 31's medical records indicated the following physician's orders: a. Divalproex sodium (generic for Depakote, a medication used to treat various psychiatric and neurological conditions) 250 mg DR (delayed release) tablet. Take one tablet by mouth every 12 hours for bipolar disorder m/b mood swings. Monitor behaviors and side effects . dated 10/8/24; and b. Olanzapine 5 mg tablet. Take one tablet by mouth every morning for schizophrenia m/b auditory hallucinations/hearing voices. Monitor for behaviors and side effects every shift dated 10/8/24. A review of Resident 31's medical records included February 2025 Behavior Monitoring Records (BMR) for divalproex sodium, mirtazapine, and olanzapine. The following behaviors were documented for divalproex sodium: one episode of mood swings on 2/1/25, 2/16/25 and 2/19/25. The following behavior was documented for olanzapine: one episode of auditory hallucinations on 2/27/25. The medical record also included a blank form, Resident 31's February 2025 NPI Flow Sheet. A review of Resident 31's medical records included a care plan for bipolar, updated 3/7/25. The bipolar disorder care plan intervention indicated Provide Non-Drug Interventions and document on non medication intervention sheet, when resident behavior occurs. A review of Resident 31's medical records included a care plan for schizophrenia updated 3/7/25. The schizophrenia care plan intervention indicated Use Non-Drug Interventions or Approaches to Address Behaviors in Addition to Ordered Medications. During a concurrent interview and record review on 5/1/25 at 2:57 p.m. with DON 1, Resident 31's February 2025 BMRs and February 2025 NPI Flow Sheet were reviewed. DON 1 acknowledged the medical record indicated no NPI were provided to Resident 31 in February 2025 as required. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. A review of Resident 21's medical records indicated the following physician's order: risperidone (generic for Risperdal, a medication to treat psychiatric conditions) 1 mg tablet. Take one tablet by mouth every morning and one tablet by mouth every evening for schizoaffective disorder m/b angry outburst and believing people are out to get him, monitor behaviors and side effects every shift dated 1/7/2025. A review of Resident 21's medical records included February 2025 BMR for risperidone. The following behaviors were documented for risperidone: two episodes of angry outbursts on 2/27/25 and two episodes on 2/28/25. The medical record also included a blank form, Resident 21's February NPI Flow Sheet. During an interview on 5/1/2025 at 8:56 AM with the Supervising Registered Nurse (SRN) 1, SRN 1 stated NPIs are documented whenever a resident is exhibiting a behavior. During a concurrent interview and record review on 5/1/25 at 2:57 p.m. with DON 1, Resident 21's February 2025 BMRs and February 2025 NPI Flow Sheet were reviewed. DON 1 acknowledged the medical record indicated no NPI were provided to Resident 21 in February 2025 as required. During an interview on 5/1/2025 at 3:05 PM, DON 1 stated there should be an entry on the NPI Flow Sheet whenever there is an episode of behaviors. DON 1 stated non pharmacologic interventions are important to reduce the unnecessary use of medications. DON 1 stated unnecessary use of psychotropic medications have the risk of side effects of the medications, such as groggy in the morning and falls with injury. During a review of the facility's policy and procedure (P&P) titled, Psychotropic Medication Management, last reviewed by the facility on 11/12/2024, the P&P indicated, Resident's care plan will include behavioral interventions implemented in an attempt to decrease the target behaviors.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 49613 Based on interview and record review, the facility failed to ensure the accurate provision of medication for one out of five sampled residents (Resident 1) when Resident 1 did not receive hypoglycemia (low blood sugar) medication as ordered by the prescriber. This failure had the potential for Resident 1 to experience symptoms of hypoglycemia, including confusion and dizziness. Findings: 1. A review of Resident 1's medical records indicated the following physician's orders: a. Check BS twice a day at 6:00 a.m. and 5:00 p.m., dated 7/12/24; and b. Glutose 15 gel (brand name for glucose (sugar) 15 grams, a medication to treat low blood sugar) by mouth as needed for blood sugar (BS) less than 80, dated 12/10/24. A review of Resident 1's January through April 2025 Medication Administration Records (MAR) indicated Resident 1's BS was less than 80 on the following dates and times: - 1/3/25 at 6:00 a.m. BS 70 - 3/11/25 at 6:00 a.m. BS 76 - 4/21/25 at 6:00 a.m. BS 78 The January through April 2025 MARs indicated Resident 1 did not receive Glutose 15 as ordered on any of the above dates. During a concurrent interview and record review on 5/1/25 at 2:47 p.m. with the Director of Nursing (DON) 1, Resident 1's January, February, March, and April 2025 MARs and physician's orders were reviewed. DON 1 stated Resident 1 was supposed to receive Glutose 15 on 1/3/25, 3/11/25, and 4/21/25 because Resident 1's blood sugar was less than 80. DON 1 verified the physician's orders were not followed. A review of the facility's policy and procedure titled, Administering Medications, reviewed 2/1/25, indicated, . Medications must be administered in accordance with the orders .

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. 49613 Based on interview and record review, the facility failed to ensure two of five sampled residents (Resident 1 and 31) were free of unnecessary medications when blood pressure (BP) and blood sugar (BS) hold parameters were not followed with the administration of medications. This failure had the potential for unnecessary medications for Residents 1 and 31, which can lead to side effects such as low blood pressure and low blood sugar. Findings: 1. A review of Resident 1's medical records indicated the following physician's orders: a. Hold diabetes medications if BS is less than 110 at 6:00 a.m., dated 12/10/24; b. Check BS twice a day at 6:00 a.m. and 5:00 p.m., dated 7/12/24; and c. Januvia (brand name for sitagliptin, a medication for diabetes) 100 milligrams (mg), take one tablet by mouth daily at 6:00 a.m. for diabetes, dated 12/10/24. A review of Resident 1's January 2025 Medication Administration Record (MAR) indicated Resident 1's BS was less than 110 at 6:00 a.m. on the following dates: - 1/25/25 BS 107 - 1/28/25 BS 90 The January 2025 MAR indicated Resident 1 received a Januvia dose on both dates. A review of Resident 1's February 2025 MAR indicated Resident 1's BS was less than 110 at 6:00 a.m. on the following dates: - 2/13/25 BS 86 - 2/15/25 BS 90 The February 2025 MAR indicated Resident 1 received a Januvia dose on both dates. A review of Resident 1's March 2025 MAR indicated Resident 1's BS was less than 110 at 6:00 a.m on the following dates: - 3/11/25 BS 76 - 3/22/25 BS 95 - 3/26/25 BS 83 (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 3/27/25 BS 100 The March 2025 MAR indicated Resident 1 received a Januvia dose on the above four dates. A review of Resident 1's April 2025 MAR indicated Resident 1's BS was less than 110 at 6:00 a.m on the following dates: - 4/21/25 BS 78 - 4/29/25 BS 90 The April 2025 MAR indicated Resident 1 received a Januvia dose on both dates. During a concurrent interview and record review on 5/1/25 at 10:02 a.m. with the Director of Staff Development (DSD) 1, Resident 1's physician orders and MAR were reviewed. DSD 1 stated the physician's orders to hold diabetes medication for BS less than 110 at 6:00 a.m. meant Januvia was supposed to be held on those days. DSD 1 stated if the physician's orders to hold diabetes medications are not followed, there is a risk of blood sugar dropping too low which can cause the resident to fall. During a concurrent interview and record review on 5/1/25 at 2:47 p.m. with the Director of Nursing (DON) 1, Resident 1's January, February, March, and April 2025 MARs and physician's orders were reviewed. DON 1 stated the physician's orders indicated to hold Januvia for 6:00 a.m. blood sugar reading less than 110. DON 1 acknowledged the resident incorrectly received Januvia on two dates in January 2025, two dates in February 2025, four dates in March 2025, and two dates in April 2025 (total 10 doses) when the medication was supposed to be held. DON 1 verified the physician's orders were not followed. 51705 2. During a review of Resident 31's Physician Orders on 4/30/25 at 9:11 a.m., the physician's orders indicated Resident 31 had three active orders for blood pressure medications: a. Amlodipine (generic for Norvasc, a medication for high blood pressure) 5 milligram (mg, a unit of measure) tablet. Take one tablet by mouth daily, hold for SBP (systolic blood pressure, the top number in a blood pressure reading) less than 110, dated 9/10/24. b. Chlorthalidone (generic for Thalitone, a medication for high blood pressure) 25 mg tablet. Take one tablet by mouth every morning for hypertension (blood pressure), hold if SBP less than 110 or if DBP (diastolic blood pressure, the bottom number in a blood pressure reading) less than 50, dated 9/10/24. c. Metoprolol succinate (generic for Toprol XL, a medication for high blood pressure) 50 mg ER (extended release). Take one tablet by mouth every evening. Hold if SBP less than 110, DBP less than 50 or HR (heart rate) less than 50, ordered 9/10/24. The holding parameters were updated to hold if SBP less than 105, HR less than 50 on 2/7/25. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/1/25 at 8:56 a.m., with Supervising Registered Nurse (SRN) 1, SRN 1 stated nurses administer blood pressure medications upon receiving physician orders and ensuring it meets the prescribed parameters. SRN 1 stated the process for documenting held medications is for nurses to initial the MAR, circle their initials and write the reason why it was held (not given) on the back of the MAR. A review of Resident 31's January 2025 MAR indicated Resident 31's SBP was less than 110, but Resident 31 received a metoprolol succinate dose on the following date: - 1/31/25 at 5 p.m., blood pressure 100/50 A review of Resident 31's February 2025 MAR indicated Resident 31's SBP was less than 110, but Resident 31 received a metoprolol succinate dose on the following date: - 2/5/25 at 5 p.m., blood pressure 105/54 A review of Resident 31's April 2025 MAR indicated Resident 31's SBP was less than 110, but Resident 31 received a dose of amlodipine and chlorthalidone on the following date: - 4/16/25 at 8 a.m., blood pressure 109/57 A concurrent interview and record review was conducted on 5/1/25 at 11:38 a.m., with the Director of Staff Development (DSD) 1 of Resident 31's February 2025 MAR. Resident 31's blood pressure was documented as 105/54 on 2/5/25 at 5 p.m. An initial without a circle was observed on the MAR for 2/5/25 for the metoprolol succinate dose. DSD 1 stated, If I don't see [initials] circled, I'd have to assume [the medication] was given. DSD stated the 2/5/25 metoprolol succinate dose was not held. A concurrent interview and record review was conducted on 5/1/25 at 2:38 p.m., with the Director of Nursing (DON) 1 of Resident 31's January through April 2025 MARs. DON 1 stated the metoprolol succinate was given on 1/31/25, but should have been held because the SBP was less than 110. Resident 31's February MAR indicated that Resident 31's blood pressure was 105/54 on 2/5/25 at 5 p.m. DON 1 stated that the 2/5/25 metoprolol succinate dose should've been held. Resident 31's blood pressure on 4/16/25 at 8 a.m., was documented as 109/57 on Resident 31's April 2025 MAR. DON 1 stated the amlodipine and chlorthalidone doses were not held because no circle. A drug literature review of amlodipine on Daily Med (an electronic drug information source) updated 12/15/08, indicated amlodipine side effects include, but are not limited to edema (swelling), flushing (increased blood flow to the surface of the skin) and palpitations (feeling one's own heartbeat, which may feel like its racing or pounding). A drug literature review of chlorthalidone on Daily Med updated 10/9/24, indicated chlorthalidone side effects include, but are not limited to dizziness, muscle weakness, nausea, vomiting, orthostatic hypotension (a drop in blood pressure upon standing from a seated or lying position). A drug literature review of metoprolol succinate on Daily Med updated 2/14/25, indicated metoprolol succinate side effects include, but are not limited to dizziness, bradycardia (slow heart rate), tiredness and hypotension. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy and procedures (P&P) titled, Administering Medications, last reviewed by the facility on 2/1/25, indicated: .Medications must be administered in accordance with the orders . and .if a drug is withheld .the individual administering the medication will ensure their initials are circled on the MAR and the reason why the medication was not administered will be documented in the space provided .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 51705 Based on observation, interview, and record review, the facility failed to ensure medications were stored appropriately when two boxes of eye drops were found in a bin labeled and full of ear drops in one of one sampled medication rooms. This failure had the potential for residents to receive the wrong medication, which could result in the residents experiencing negative health outcomes. Findings: During a concurrent observation and interview on 4/28/25 at 11:56 a.m., with the Director of Staff Development (DSD) 1, a tour of the Skilled Nursing Facility (SNF) unit medication room was conducted. Eight boxes of ear drops were observed in a black bin labeled, EAR DROPS. Two boxes of eye drops (one box of Refresh and one box of Visine, both used to treat dry eyes) were also stored in the same bin. DSD acknowledged two eye drops were in the ear drop bin. During a concurrent interview and record review on 5/1/25 at 2:27 p.m., with the Director of Nursing (DON) 1, the facility's policy and procedure (P&P) titled, Storage of Medications, last reviewed by the facility on 5/31/24 was reviewed. The P&P indicated, .Medication Storage Requirements .Eye medications are kept separate from ear medications . DON 1 acknowledged eye drops and ear drops should be stored separately from each other.