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| SPRINGS ROAD HEALTHCARE | 1527 SPRINGS ROAD VALLEJO, CA 94591 |

POC Received 4/7/25
POC Approved 4/9/25
BIC = 3/24/25 per HQ

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| F 000 | INITIAL COMMENTS<br><br>The following reflects the findings of the California Department of Public Health during a Federal Recertification Survey.<br><br>The facility census was 61. The sample size was 24.<br><br>One (1) complaint #CA00950224 was investigated during the Recertification Survey.<br><br>The Department was unable to substantiate a violation of the regulations for the complaint #CA00950224. | F 000 | *This document will serve as a credible allegation of our intent to correct the deficient practice identified. Preparation and/or execution of this Plan of Correction do not constitute admission or agreement, by the provider, of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because it is required by the provisions of Health and Safety Code Section 1280 and 42 C.F.R. 405.1907.* | |
| F 550 SS=E | Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all | F 550 | **How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**<br><br>The curtains that were not reaching around, and the missing and/or broken blinds were immediately addressed and repaired by the maintenance director for residents 108, 51, 01, and 10 to preserve their dignity and uphold their rights.<br><br>To date, the curtains for the affected residents fully close, providing adequate privacy; and the blinds are complete and in working condition.<br><br>The residents were reassured and expressed satisfaction with the outcomes. | |

Connor Airey, Administrator 3/28/2025
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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.



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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

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| F 550 | Continued From page 1<br>residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights.<br>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.<br><br>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.<br><br>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record record review, the facility failed to ensure four of 21 sampled residents (Residents 108, 53, 1, and 10) in a census of 61 privacy when curtains did not reach around personal space and vertical blind slats were missing.<br><br>These failures resulted Resident 10 felt ashamed and increased the potential for increased feelings of reduced self esteem and embarrassment.<br><br>Findings:<br><br>Resident 108 was admitted to the facility in the winter of 2025 with diagnoses which included muscle weakness and difficulty walking.<br><br>During a review of Resident 108's Minimum Data Set (MDS, an assessment tool), dated 3/4/25, the | F 550 | **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:**<br><br>All residents can potentially be affected by the alleged deficient practice as failure of the facility to ensure that residents were treated with dignity and their privacy was protected when curtains did not reach around the resident's personal space and vertical blinds were broken/missing.<br><br>Upon identification of alleged deficient practice, the Maintenance Director made rounds to the other rooms and no similar findings identified.<br><br>**What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur:**<br><br>It is the policy of the facility to ensure that residents are afforded privacy and dignity through adequate curtain coverage and complete and properly functioning blinds.<br><br>On 3/11/2025, the Director of Staff Development (DSD) conducted an in-service to Maintenance Director, Housekeeping, Certified Nursing Assistants (CNA), Licensed Nurses (LN), and all other staff regarding policy and procedure on resident's rights with emphasis on dignity, privacy, and call light response through curtains reaching around them, and functional blinds.<br><br>Licensed Nurses (LNs), Certified Nursing Assistants (CNAs), Housekeeping Staff, interdisciplinary team (IDT) managers, and all other staff will continue to note in the maintenance log any issues regarding curtains and/or blinds in resident's rooms.<br><br>The Maintenance Director/Designee will review the log on a daily basis and address any concerns.<br><br>During their rounds, IDT managers will assess the functionality of curtains and blinds and document findings in their room round sheets accordingly, and notify maintenance director/designee immediately. | |

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| F 550 | Continued From page 2<br>MDS indicated Resident 108 had moderate memory impairment.<br><br>During a review of Resident 108's care plan (CP), titled "Potential for alteration r/t [related to]...ADL support for...toileting...," dated 3/6/25, the CP indicated "Provide privacy..."<br><br>During a concurrent observation and interview in a shared bedroom on 3/10/25 at 9:02 a.m., as Resident 108's curtains were being checked for coverage of the resident's personal space, Resident 108 began independently disrobing at her bedside. The curtains did not reach around her bed and she was visible from the hallway with her upper body naked and exposed. Resident 108 was asked how it made her feel and she responded, "Not good!"<br><br>Resident 53 was admitted to the facility in the winter of 2025 with diagnoses which included muscle weakness, difficulty walking and reduced mobility.<br><br>During a review of Resident 53's MDS, dated 1/22/25, the MDS indicated Resident 53 had moderate impairment of her memory.<br><br>During a review of Resident 53's CP, untitled, dated 1/27/25, the CP indicated "MAINTAIN RESIDENT'S PRIVACY..."<br><br>During an observation of Resident 53's personal space on 3/10/25 at 9:03 a.m., the privacy curtains did not reach around the bed for privacy and one slat of vertical blinds was missing across sliding door with the courtyard visible outside.<br><br>During a concurrent observation and interview on | F 550 | **How does the facility plan to monitor its performance to make sure that solutions are sustained?**<br><br>Findings from facility rounds/maintenance log will be discussed during Daily Stand-up meetings. Administrator/designee will monitor for compliance. Interventions to be reviewed in the next QAPI meeting. The administrator will bring 2567 and POC to the QAPI meeting to discuss and ensure understanding for the next 3 months or until substantial compliance is achieved.<br><br>**Completion Date: 03/11/2025** | |





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| F 550 | Continued From page 3<br>3/10/25 at 9:04 a.m. with the Social Services Assistant (SSA), the SSA verified the curtain did not reach around residents space and a vertical blind was missing, so that Resident 108 and Resident 53 did not have complete privacy.<br><br>During an interview on 3/10/25 at 10:58 a.m. with Resident 53, Resident 53 stated, "That missing slat bothers me. I've mentioned it several times [to staff]. I don't know why they haven't replaced it...You can see directly into [Resident 108 and Resident 53's] room from across the patio from another room. I've seen it [from another room across the courtyard]."<br><br>Resident 1 was admitted to the facility in the winter of 2025 with diagnoses which included muscle weakness, difficulty walking and reduced mobility.<br><br>During a review of Resident 1's MDS, dated 2/10/25, the MDS indicated Resident 1 had moderate impairment of her memory.<br><br>During a review of Resident 1's CP, titled "ALTERATION IN ELIMINATION...ADL support for...toileting...," dated 1/17/25, the CP indicated "Provide privacy..."<br><br>During a concurrent observation and interview on 3/10/25 at 9:30 a.m. with Resident 1, a slat was missing from the vertical blinds covering a window. Resident 1 stated, "At night I don't like it because I think people are spying on me. I've seen people out there [on the patio]..."<br><br>Resident 10 was admitted to the facility in the fall of 2024 with diagnoses which included muscle weakness, difficulty walking and reduced mobility. | F 550 | | |





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| F 550 | Continued From page 4<br><br>During a review of Resident 10's CP titled "ALTERATION IN ELIMINATION...ADL support for...toileting...," dated 11/26/24, the CP indicated "Provide privacy..."<br><br>During a review of Resident 10's MDS, dated 2/24/25, the MDS indicated Resident had severe memory impairment.<br><br>During an observation on 3/10/25 at 9:58 a.m. Resident 10 was observed from the doorway of the bedroom while she was being changed. The privacy curtain was pulled forward on both sides but at the foot of the bed, the resident's perineal [the bottom region of your pelvic cavity] area was visible from the doorway. Resident 20's back, buttocks and perineal area were exposed.<br><br>During a concurrent observation and interview on 3/10/25 at 10:01 a.m. with Certified Nurse's Assistant (CNA)1, CNA 1 acknowledged Resident 10 's bottom was exposed, yet CNA 1 continued to change Resident 10 without pulling the moveable curtain (available at the foot of a roommate's bed), as other people walked in the hallway past the open doorway of Resident 10's room. CNA 1 indicated the curtain was for use to provide privacy for each of the three residents in the room and verified it could be pulled across the foot of each bed. CNA 1 stated she didn't want to bother [to pull it across] because it got her roommate, "upset when you move her stuff around."<br><br>During an interview on 3/11/25 at 9:09 a.m. with Resident 10, Resident 10 was asked how the exposure made her feel. Resident 10 indicated she felt ashamed when people saw her being | F 550 | | |



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| F 550 | Continued From page 5<br>changed and wanted privacy. Resident 10 also indicated the staff only used the two side curtains. They did not cover the foot of the bed when they changed her. Resident 10 indicated even her roommates saw her when [staff] did not pull the curtains at the foot of the bed.<br><br>During an interview on 3/10/25 at 10:22 a.m. with the Administrator (ADM), the ADM stated his expectations for privacy was, "Residents should be given privacy when being changed or cared for."<br><br>During an interview on 3/11/25 at 8:59 a.m. with the Director of Nurses (DON), the DON stated, "Curtains should be pulled all the way around for privacy."<br><br>During a review of the Maintenance Log (ML), dated 1/25, 2/25 and 3/25, no entry was found for repair of the curtains or blinds in the rooms of Residents 108, Resident 53, or Resident 1.<br><br>During a review of the facility policy and procedure (P&P), dated 2/24, the P&P indicated, "Each resident shall be cared for in a manner that promotes and enhances his or her sense of well being, level of satisfaction with life, feeling of self worth and self esteem...promote and protect resident privacy, including bodily privacy during assistance with personal care..." | F 550 | | |
| F 755 SS=D | Pharmacy Srvcs/Procedures/Pharmacist/Records<br>CFR(s): 483.45(a)(b)(1)-(3)<br><br>§483.45 Pharmacy Services<br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in | F 755 | **How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**<br><br>Resident 35 was assessed and no concerns were noted.<br><br>The medical director was notified of the alleged deficient practice.<br><br>Pharmacy Consultant and the Nurse Practitioner reviewed the current medications order of Resident 35 on 3/24/2025. | |

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| F 755 | Continued From page 6<br>§483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-<br><br>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and<br><br>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the facility failed to ensure an accurate inventory of narcotics (a medication that is used to relieve pain) for one of three sampled residents (Resident 35) when two tablets of narcotics were not entered into the residents Medication Administration Record (MAR, document that serves as a legal record of the drugs administered to a resident). | F 755 | Licensed Nurses (LNs) who failed to ensure accurate inventory/documentation of narcotic medication received a 1:1 in-service education on 03/24/2025 by the Director of Nursing Services (DNS) related to appropriate procedures on narcotic medication administration and documentation.<br><br>The DNS provided in-service training to all LNs on 03/24/2025 on the correct procedures on administering and signing off narcotic medications in order to maintain an accurate reconciliation.<br><br>**How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:**<br><br>All residents have the potential to be affected by the alleged deficient practice as failure to keep accurate inventory of narcotics can lead to potential drug diversion resulting in improper drug usage and harm.<br><br>Resident 35 narcotics was audited on 3/13/2025 and all residents currently receiving a narcotic pain medication were audited by the DNS/Designee on 03/14/2025 to ensure accurate inventory of narcotics. Effectiveness, location and intensity were documented after the PRN narcotic pain medication to evaluate their pain level.<br><br>Upon identification of the alleged deficient | |

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| | This failure had the increased potential for drug | | practice, a new pain assessment was conducted on residents noted to have been given a PRN narcotic pain medications for the last 7 days to evaluate their pain level and ensure accurate inventory of narcotic had been documented in eMAR. No similar issue identified. | |





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| F 755 | Continued From page 7<br>diversion (when healthcare staff obtain and use prescription medicines illegally), and inaccurate monitoring of the amount and frequency of medications given to the resident.<br><br>Findings:<br><br>Resident 35 was admitted to the facility in 2019. The current principal diagnosis was acute respiratory failure (when the body does not get enough oxygen or there is too much carbon dioxide in the body).<br><br>During a review of Resident 35's physician orders (PO) dated 3/13/25, the PO indicated, "Percocet (oxycodone-acetaminophen, medications used to relieve pain) Oral Tablet 10-325 MG (milligram, unit of measurement, used for medication dosage and/or amount) Give 1 tablet ...every 4 hours as needed for ...pain."<br><br>During a review of Resident 35's "CONTROLLED DRUG RECORD (CDR), Individual Patient's Narcotic Record (a form that keeps count of the number of narcotics dispensed to a resident)," indicated one tablet of Percocet was removed from the medication card (pre-packaged medications dispensed from a pharmacy) on 2/23/25 at 10:06 a.m. and one table of Percocet was removed on 2/27/25 at 6:45 p.m.<br><br>During a review of Resident 35's MAR dated 2/1/25 - 2/28/25, the MAR did not show documentation of Percocet being administered on 2/23/25 at 10:06 a.m. or on 2/27/25 at 6:45 p.m. There were a total of two Percocet that were signed out from the narcotic medication card but were not documented as given to Resident 35. | F 755 | **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:**<br><br>It is the policy of the facility to ensure accurate inventory of narcotics are entered in e MAR to prevent the potential for diversion.<br><br>The DNS provided in-service training to all LNs on 03/24/2025 on the correct procedures on administering and signing off narcotic medications in order to maintain an accurate reconciliation.<br><br>LNs in their respective shifts will ensure that accurate inventory of narcotics are entered in e MAR to prevent the potential for diversion.<br><br>The DNS/Designee will conduct medication pass observations daily x 1 week and weekly x 3 months to ensure licensed nurses are following the protocol on narcotic medication administration and documentation.<br><br>**How the facility plans to monitor its performance to make sure that solutions are sustained:**<br><br>The DNS/Designee will monitor for compliance.<br><br>Findings identified will be presented to the monthly QAPI meeting for 3 months for follow up and recommendations. The administrator will bring 2567 and POC to the QAPI meeting to discuss and ensure understanding for the next 3 months or until substantial compliance is achieved.<br><br>**Completion Date: 03/24/2025** | |

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| F 755 | Continued From page 8<br>During a concurrent interview and record review on 3/13/25 at 10:39 a.m. with the Director of Nursing (DON) of Resident 35's records, the DON confirmed the CDR documentation did not match the MAR documentation. The DON confirmed there was no way of knowing if narcotics were given to Resident 35, and it should have been documented in the residents MAR if given.<br><br>During a review of the facility's policy and procedure (P&P) titled, "Administering Pain Medications," dated 2001, the P&P indicated, "Document the following in the resident's medical record: 1. Results of the pain assessment; 2. Medication; 3. Dose ..." | F 755 | | |
| F 756 SS=D | Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)<br><br>§483.45(c) Drug Regimen Review.<br>§483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>§483.45(c)(2) This review must include a review of the resident's medical chart.<br><br>§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.<br>(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that sent to the attending physician and the facility's medical | F 756 | **How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**<br><br>Resident 34 was assessed and no concerns were noted.<br><br>The Medical Director was immediately notified of the alleged deficient practice. Pharmacy Consultant and the Nurse Practitioner reviewed the current medications order of Resident 34 on 03/24/2025.<br><br>The facility will continually strive to monitor resident's drug regimen reviews and Pharmacy reports regarding recommendations to physicians. The facility has Policies and Procedures designed to maintain these goals. Pharmacy review, consultant reviews, quality assurance monitoring and staff training are examples of the many components utilized to achieve a complete drug regimen review process. | |

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| | | | 1:1 in service education provided by the Director of Nursing Services (DNS) on 03/12/2025 to Licensed Nurses (LNs) with emphasis given on the importance of carrying out PRN psychotropic medication orders to include end date or the duration of 14 days.<br><br>On 03/24/2025, the Pharmacy Consultant reviewed the Psychotropic medication of Resident 34. Additionally, it was also reviewed and addressed by the Nurse Practitioner on the same day. | |





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| F 756 | Continued From page 9<br>director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.<br><br>§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, the facility failed to ensure one of 24 sampled residents (Resident 34) received a thorough monthly pharmacy medication regimen review (MRR).<br><br>This failure placed Resident 34 at risk for receiving unnecessary, ineffective, and/or excessive dose of Lorazepam (a psychotropic medication to treat anxiety).<br><br>Findings:<br><br>Resident 34 was admitted to the facility with diagnoses including thickening and hardening of the walls of the arteries in the brain and anxiety disorder.<br><br>Review of the admission MDS (Minimum Data | F 756 | **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:**<br><br>All residents have the potential to be affected by this alleged deficient practice as failure to follow up psychotropic medications with a stop date as indicated could lead to unnecessary, ineffective, and/or excessive dosage of psychotropic medication.<br><br>The Pharmacy Consultant were immediately notified about the findings who subsequently reviewed the psychotropic medication of Resident 34 and other residents.<br><br>Follow up meeting with Nurse Practitioner and Pharmacy Consultant held on 3/24/2025 in the DNS's office to ensure the monthly drug regimen review process will be implemented.<br><br>Care was coordinated with hospice and the needs for continuing the psychotropic medication.<br><br>The drug regimen of each resident must be reviewed at least once a month by a Consultant pharmacist.<br><br>No other residents were found to be affected at this time. | |





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| **SPRINGS ROAD HEALTHCARE** | **1527 SPRINGS ROAD VALLEJO, CA 94591** |

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| F 756 | Continued From page 10<br>Set, an assessment tool) indicated the resident scored 5/15 in the BIMS (Brief Interview for Mental Status, a cognitive assessment) which suggested he had severe cognitive impairment.<br><br>Review of Resident 34's medical record indicated the resident had a physician order, dated 5/31/24, for Lorazepam 0.5 MG (milligram) to give 1 tablet by mouth every 6 hours as needed for anxiety for 14 day(s). There was no physician order to renew Lorazepam 0.5mg 14 days after the 5/31/24 order until 10/12/24.<br><br>Review of the Medication Administration Record (MAR) from May 2024 through October 2024 indicated Resident 34 received Lorazepam 0.5 mg until 10/3/24.<br><br>During a concurrent interview and records review on 3/12/25 at 9 a.m., with the Director of Nursing (DON), the DON confirmed that as needed Lorazepam 0.5mg was ordered on 5/31/24 for a 14-day period, but it continued to be administered until 10/3/2024 for Resident 34 without a physician order for continuation. The DON also verified there had been no monthly MRR for Resident 34 from May 2024 through December 2024 and acknowledged the irregularities in Lorazepam administration could have been identified by the pharmacist, had the MMR been performed.<br><br>In a telephone interview on 3/12/2025 at 2:12 p.m., with the Pharmacy Consultant (PC), the PC confirmed the monthly MRR was not provided for Resident 34 from May 2024 through October 2024 and acknowledged MRR should have been provided monthly. The PC stated, "It [Lorazepam 0.5 mg] was ordered for 14 days, my | F 756 | **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:**<br><br>It is the policy of the facility to ensure residents on psychotropic medications receive a thorough monthly pharmacy medication regimen review (MRR) to prevent the risk for residents receiving unnecessary, ineffective, and/or excessive dosage.<br><br>DNS provided in-service on 03/12/2025 to LNs regarding the policy and procedure for carrying out medication orders, including Psychotropic Medications, with emphasis given on the importance of observing the stop date of PRN psychotropic medications when writing the orders.<br><br>LNs to ensure that the stop date of Psychotropic medications are observed.<br><br>DNS to review the accuracy of new PRN orders daily.<br><br>The Pharmacy Consultant will review the medication regimen of each resident at least monthly or as needed and provide a written report to the DNS and the Attending Physicians.<br><br>DNS/Designee to ensure and verify that monthly Drug regimen review will be conducted by the Pharmacy and are implemented.<br><br>**How the facility plans to monitor its performance to make sure that solutions are sustained:**<br><br>The DNS/Designee will monitor for compliance.<br><br>Findings identified will be presented to the monthly QAPI meeting for 3 months for follow up and recommendations. The administrator will bring 2567 and POC to the QAPI meeting to discuss and ensure understanding for the next 3 months or until substantial compliance is achieved.<br><br>**Completion Date: 03/24/2025** | |

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| F 756 | Continued From page 11<br>understanding is that when it's written that way it should automatically stop [after 14 days]."<br><br>During a review of the Facility's May 2019 policy and procedure (P&P), Medication Regimen Reviews, indicated, "The Consultant Pharmacist reviews the medication regimen of each resident at least monthly ...the Consultant Pharmacist provides a written report to the attending physicians ...the report contains ...d. The pharmacist's recommendation."<br><br>During a review of the facility's P&P titled, Psychotropic Medications Use, dated April 8, 2022, the P&P indicated, " ...PRN orders for psychotropic drugs are limited to 14 days ...Pharmacy will review psychotropic medication usage on admission, monthly, and as needed." | F 756 | | |
| F761 SS=E | Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§483.45(h)(2) The facility must provide separately | F761 | **How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**<br><br>Upon identification of the alleged deficient practice, the following were conducted:<br><br>a. Resident 54's insulin label was immediately corrected to reflect the correct order. New NPH insulin was also ordered from the Pharmacy with the updated label. Resident 54 was assessed for signs and symptoms of hyper/hypoglycemia, none were observed.<br><br>b. New Inhaler medications were ordered from the facility pharmacy.<br><br>c.The three (3) Inhalation Aerosols and Biktarvy were shown to the Pharmacy Consultant, reviewed and verified the medications during his visit on 3/24/2025. All Medications were properly labeled to indicate proper identification, right dosage and expiration.<br><br>d. The Lidocaine and Inhalation powder that had no open dates were immediately discarded and new medications were ordered from the pharmacy.<br><br>Pharmacy Consultant informed pharmacy to deliver a new sticker indicating the right identification and dosages of the medication.<br><br>1:1 in service education provided by the Director of Nursing Services (DNS) on 03/11/2025 to LN1 | |

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| | | | regarding change of direction and proper labeling of medications and the need to inform Pharmacy regarding medication order changes. | |



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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

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| F 761 | Continued From page 12<br>locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to accurately label medications for a census of 61 when:<br><br>1. Resident 54's insulin order was not reflected correctly on the medication label, and<br>2. The medications lacked resident labels and open dates, and the label was unclear and difficult to read.<br><br>These failures had the potential for residents to receive the wrong medications, incorrect dosages of medications, and expired medications.<br><br>Findings:<br><br>1. During a concurrent observation and interview on 3/11/25 at 8:55 a.m. during medication administration with Licensed Nurse ( LN 1), LN 1 administered 14 units (unit of measurement) of Humulin N (is an intermediate-acting insulin given to help control blood sugar levels in people with diabetes [a chronic condition that affects the way the body processes blood sugar]) 100Units/ml (milliliter, unit of measurement) to Resident 54. The resident's medication label both on the box, and the vial indicated "inject 10 units..." LN 1 verified in Resident 54's Medication Administration Record (MAR, document that | F 761 | **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:**<br><br>All residents have the potential to be affected by this alleged deficient practice as failure to correctly label medication could result in providing wrong medications, incorrect dosages, and expired medications to residents.<br><br>An immediate sweep of medication carts station 1 and station 2 was conducted by the Director of Staff Development (DSD) to ensure there were no additional medications with lacking resident labels and open dates, and the label that was unclear and difficult to read. No other residents were found to be affected at this time.<br><br>**What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:**<br><br>It is the policy of the facility that medication must be properly labeled consistent to the order, labels must be legible at all times and any medication packaging or containers that are inadequately or improperly labeled are returned to the issuing pharmacy. | |





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| F 761 | Continued From page 13<br>serves as a legal record of the drugs administered to a resident) included the physician order for Humulin N 14 units every morning and 14 units every night. LN 1 confirmed that Resident 54 had a change to their medication dosage and that it was not correctly reflected on Resident 54's medication label.<br><br>During an interview on 3/13/25 at 10:46 a.m. with the Director of Nursing (DON), the DON was asked what the expectations were for labeling medications with a change in order. The DON stated, "If the order changes, per policy, we need to place a sticker, 'change in direction', that will be put on the medication." The DON stated that the pharmacist should be called for a new, accurate resident label and that the label would be delivered during the scheduled delivery time.<br><br>During a review of the facility's policy and procedure (P&P) titled, "Labeling of Medication Containers," dated 2001, the P&P indicated, "Any medication packaging or containers that are inadequately or improperly labeled are returned to the issuing pharmacy...Labels for individual resident medications include all necessary information such as...cautionary statements...The nursing staff must inform the pharmacy of any changes in physician orders for a medication..."<br><br>2. A concurrent observation and interview on 3/11/25 at 2:23 p.m. with LN 1, one of two medication storage carts was inspected. During the observation, one bottle of Biktarvy (a medication to treat human immunodeficiency virus [HIV]) 50 mg/200 mg/25 mg (milligram, unit of measurement), two Breyna Inhalation Aerosol (inhaler, a medication that is delivered in a fine mist and inhaled through the mouth and into the | F 761 | 1:1 in service education provided by the DNS on 03/11/2025 to Licensed Nurse 1 (LN 1) and to other LNs regarding the policies and procedures on “Labeling of Medication Containers” and “Storage of Medications” with emphasis on the following:<br><br>a. Ensuring that medications are properly labeled including medications brought by family into the facility.<br><br>b. Returning to the issuing pharmacy any medications that are improperly labeled.<br><br>c. Notifying the pharmacy of any changes in the physician’s orders.<br><br>Upon receipt of any delivery of medication from the pharmacy, LNs must ensure medications are properly labeled. The issuing Pharmacy must be notified for any issues.<br><br>During medication pass, LNs must ensure that medications are properly labeled consistent to the order.<br><br>Any medication brought by the family to the facility must be verified and ensure that proper labels are available. Any issues will be communicated to the DNS and the facility pharmacy.<br><br>**How the facility plans to monitor its performance to make sure that solutions are sustained:**<br><br>The DNS/Designee will audit Medication carts at Station 1&2 bi-weekly x 3 months to ensure compliance.<br><br>Findings identified will be presented to the monthly QAPI meeting for 3 months for follow up and recommendations. The administrator will bring 2567 and POC to the QAPI meeting to discuss and ensure understanding for the next 3 months or until substantial compliance is achieved.<br><br>**Completion Date: 03/24/2025** | |

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| F 761 | Continued From page 14<br>lungs) 160 mcg/4.5 mcg(microgram, unit of measurement), and one unidentifiable inhalation aerosol were found with no resident labels. One Symbicort Inhalation Aerosol 160 mcg/4.5 mcg was found with an resident label that was difficult to read. Two Anoro Ellipta Inhalation Powder (a dry, powdered form of medication that is inhaled into the lungs) 62.5 mcg/25 mcg, and one bottle of Lidocaine Viscous 2% Oral Topical Solution (a medication used to treat pain in the mouth or throat) were found without open dates. LN 1 confirmed that the three inhalation aerosols and the Biktarvy were missing resident labels and Lidocaine and inhalation powder had no open dates, and one label on an inhalation aerosol were difficult to read.<br><br>During an interview on 3/13/25 at 10:46 a.m. with the DON, the DON was asked what the expectations were regarding illegible labels, open date labeling, and medications with no resident label. The DON stated that you should be able to read the label. The DON confirmed that the label on the inhaler was difficult to read and needed to be replaced. The DON stated that if a medication was not labeled, the pharmacy needed to be contacted and the medication to be verified with the pharmacy. Further stating, "The medication should be sent to the pharmacy for confirmation, and to be properly labeled." The DON stated once a medication was opened, an open date needed to be labeled on the medication. The DON confirmed that there were no open dates on the Lidocaine and both inhalation powders, and that she expected them to be discarded. The DON confirmed that the three inhalation aerosols had no resident labels. | F 761 | | |

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| | During a review of the facility's P&P titled, | | | |





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| F 761 | Continued From page 15<br>"Labeling of Medication Containers," dated 2001, the P&P indicated, "Medication labels must be legible at all times...Any medication packaging or containers that are inadequately or improperly labeled are returned to the issuing pharmacy."<br><br>During a review of the facility's P&P titled, "Storage of Medications," dated 2001, the P&P indicated, "Drug containers that have missing, incomplete, improper or incorrect labels are returned to the pharmacy for proper labeling before storing." | F 761 | | |
| F 880<br>SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; | F 880 | **How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**<br><br>The identified lounge chairs in the dining/activity room were removed by the facility's Maintenance Director immediately upon identification of the alleged deficient practice.<br><br>No residents were found to be affected. | |





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| F 880 | Continued From page 16<br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review. | F 880 | **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be Taken:**<br><br>All residents have the potential to be affected by this alleged deficient practice as failure to provide a clean, sanitary environment could potentially spread communicable diseases.<br><br>The Infection Preventionist (IP) and Maintenance Director did a facility sweep for any equipment that could possibly pose a risk for the spread of communicable diseases, no similar item found.<br><br>No other residents were found to be affected by the alleged deficient practice.<br><br>**What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:**<br><br>It is the policy of the facility to ensure that a safe and clean environment is provided to the residents and preventative measures are taken to reduce the spread of infections.<br><br>Inservice was provided to all staff on 03/12/2025 by the IP on the facility policy for infection control with emphasis on the importance of providing a sanitary environment to mitigate the risk for the transmission of communicable diseases.<br><br>The facility will ensure that all resident equipment is clean, sanitized, and in good working condition daily during manager room rounds. Any issues will be reported to the Administrator/Maintenance Director/Designee. | |

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| F 880 | Continued From page 17<br>The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to ensure infection prevention and control program were maintained and to provide a sanitary environment when two lounge chairs in the dining/activity room were worn out, threadbare and available for resident use. This failure increased the risk for the transmission of communicable diseases.<br><br>Findings:<br><br>During an observation on 3/10/25 at 12:03 p.m., two large wing-back lounge chairs made of imitation leather were badly worn with mesh and foam showing through and available for use in the dining/activity room for use. Resident 51 was seen moving between and sitting in both lounge chairs.<br><br>During a concurrent observation and interview on 3/10/25 at 12:05 p.m. with the Infection Preventionist (IP), the IP verified observation and stated, "The lounge chairs used to be covered in leather. [The material] appears to be man made with the fabric lining and foam showing through. It can't be sanitized properly due to the mesh fabric."<br><br>During an interview on 3/11/25 at 8:59 a.m. with the Director of Nurses (DON), the DON was asked her expectations and stated, "When the furniture is worn, we need to replace it because it [because we] can't sanitize it."<br><br>During an interview on 3/13/25 at 10:03 a.m. with | F 880 | **How the facility plans to monitor its performance to make sure that solutions are sustained:**<br><br>The IP/Designee and/or Maintenance Director will audit all resident equipment weekly x 3 months to ensure that equipment is clean and in good working condition.<br><br>Findings identified will be presented to the monthly QAPI meeting for 3 months for follow up and recommendations. The administrator will bring 2567 and POC to the QAPI meeting to discuss and ensure understanding for the next 3 months or until substantial compliance is achieved.<br><br>**Completion Date: 03/12/2025**<br><br>. | |

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| F 880 | Continued From page 18<br>the Maintenance Supervisor (MS), the MS was asked if the worn lounge chairs had been put in the maintenance log and he stated, "No one reported the two lounge chairs upholstery was deteriorating..."<br><br>During a further interview on 3/13/25 at 10:56 a.m. with the IP, the IP said, "We were aware [of the deterioration of the lounge chairs]..." The IP also indicated that multiple residents used the lounge chairs.<br><br>During a review of the Maintenance Log, dated 1/25, 2/25 and 3/25, no request for repair or replacement of the two worn lounge chairs was found.<br><br>During a review of the facility policy and procedure (P&P), titled "Infection Control," revised 10/24, the P&P indicated "The objectives of our infection control policies and practices are to...Prevent...infections in the facility...Maintain a...sanitary...environment for...residents..." | F 880 | | |