STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555595	A. BUILDING _____ B. WING _____	03/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SMITH RANCH SKILLED NURSING & REHABILITATION CENTE	1550 SILVEIRA PARKWAY SAN RAFAEL, CA 94903

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** Based on observation, interview and review of the facility's policies and procedures, the facility failed to follow the professional standard of their policy on: 1. Proper disposal of medications when a licensed nurse did not dispose of 1 of 2 sampled resident's (Resident 2's) bubble pack of [MEDICATION NAME] (treats high blood pressure) 5 mg (milligrams) from the medication cart, which led to Licensed Staff A administering Resident 2 the wrong dose of [MEDICATION NAME], 5 mg instead of 10 mg, and 2. Routine medications were not administered within one-hour of their prescribed time. These failures had the potential to cause Resident 2's blood pressure (BP) to remain high, which could cause a [MEDICAL CONDITION], stroke and/or other adverse effects on Resident 2's health, and even death. Findings: A review of Resident 2's Admission Record, indicated she was admitted on [DATE], with a [DIAGNOSES REDACTED]. relax normally because the muscle has become stiff preventing the heart to fill properly with blood during the resting period between each heart beat), [MEDICAL CONDITION] (The [MEDICAL CONDITION] does not make enough of the [MEDICAL CONDITION] hormone called [MEDICATION NAME]. This causes the body's system to slow down and can lead to fatigue, feeling cold, weight gain due to fluid retention, dry skin, and hair loss), and gastro-[MEDICAL CONDITION] reflux disease (GERD: A chronic disease that occurs when stomach acid or bile (a dark-green-to-yellow-brown fluid produced by the liver that aids the digestion of fatty acids in the small intestines) flows into the food pipe and irritates the lining). During a concurrent observation and interview on 1/30/20 at 11:21 a.m., Licensed Staff A gave Resident 2 [MEDICATION NAME] 20 mg (treats [MEDICAL CONDITION]), [MEDICATION NAME] 2.5 mg/3 ml (milliliters) nebulization treatment (treats [MEDICAL CONDITION]), [MEDICATION NAME] 10 mg (treats high blood pressure), fish oil 1000 mg (reduces inflammation in the body and prevention of cardiac death), [MEDICATION NAME] (for low [MEDICAL CONDITION] hormone) 50 mcg (micrograms), [MEDICATION NAME] 5 mg, Vitamin D3 1000 units (used as a dietary supplement to that helps the body absorb calcium, which is needed to prevent bone loss), [MEDICATION NAME] 5 mg (treats GERD), [MEDICATION NAME] 40 mg capsule delayed release (treats GERD), and multiple vitamin/minerals 1 tablet (to treat vitamin deficiency due to poor diet and certain illnesses). When Licensed Staff A was asked when the morning medications should have been given, Licensed Staff A stated she had a window of 1 hour before and 1 hour after the scheduled medication were due to be administered to the resident before the medications were late. Licensed Staff A stated she was late in giving Resident 2 all the observed morning medications. The facility police/procedure titled, Administering Medications, revised 12/12, indicated, Medications must be administered within 1 hour of their prescribed time, unless otherwise specified (for example, before and after a meal). A review of Resident 2's Summary Order Report, dated 1/30/20, Medication Administration Record [REDACTED]. [MEDICATION NAME] 20 mg was ordered to be given one time a day with meals (starting 1/28/20 for three days) and was scheduled for 8 a.m. The Resident 2's [MEDICATION NAME] should have been given with her breakfast or within 1 hour following her breakfast, but was not given with her meal or within 1 hour following her meal as directed by the facility Medication Administration Schedule. Resident 2 received her [MEDICATION NAME] 20 mg at 11:21 a.m., 2 hours (h) and 21 minutes (min) late. b. [MEDICATION NAME] 2.5 mg/3 ml (milliliters) nebulization treatment was scheduled two times per day (9 a.m. and 9 p.m.), but was given at 11:21 a.m., 1 h and 21 min late based on the facility Medication Administration Schedule. c. Resident 2's BP Summary, dated 1/30/20 at 11:09 a.m., indicated Resident 2's BP was 187/82 (Normal BP: 120/80). Resident 2 was scheduled to have her BP medication, [MEDICATION NAME] 10 mg at 9 a.m., but she was given her medication at 11:21 a.m., 1 h and 21 min late. d. Resident 2 was to be given [MEDICATION NAME] 10 mg starting on 1/30/20 daily at 9 a.m., but was given [MEDICATION NAME] 5 mg instead at 11:21 a.m., 1 h and 21 min late, with an elevated BP of 187/82, and, e. fish oil 1000 mg capsule, [MEDICATION NAME] 50 mcg tablet, Vitamin D3 1000 units tablet, [MEDICATION NAME] 5 mg tablet, [MEDICATION NAME] 40 mg capsule delayed release, and a multiple vitamin/mineral 1 tablet were all scheduled for 9 a.m., but were given at 11: 21 a.m., 1 hour and 21 min late. During a concurrent observation, interview, and record review on 1/30/20 at 1 p.m., the surveyor had indicated to Licensed Staff A, she observed her administering Resident 2 [MEDICATION NAME] 5 mg tablet by mouth at 11:21 a.m. instead of [MEDICATION NAME] 10 mg, but documented she had given [MEDICATION NAME] 10 mg. Licensed Staff A went into the medication cart drawer and noted there was two bubble packs of [MEDICATION NAME] with two different doses: one [MEDICATION NAME] bubble pack had a dose of 5 mg and, the other bubble pack had a dose of 10 mg. Licensed Staff A stated she did not realize there were two bubble packs of [MEDICATION NAME] with different doses. Licensed Staff A stated when the physician ordered [MEDICATION NAME] to be increased from 5 mg to 10 mg on 1/29/20 and to be started on 1/30/20, the bubble pack of [MEDICATION NAME] 5 mg should have been pulled from the medication cart and discarded per the facility protocol. During an interview on 1/30/20 at 12:37 p.m., Licensed Staff B stated there was a one-hour window each way on a resident's scheduled medication. Licensed Staff B stated for example: If the resident's medication was scheduled to be given at 9 a.m., the nurse could not give the medication any earlier than 8 a.m. and no later than 10 a.m. During a concurrent observation and interview on 1/30/20 at 1:40 p.m., the DON stated Resident 2's [MEDICATION NAME] 5 mg tablet bubble pack should have been pulled and placed in the locked cabinet in the medication room. Licensed Staff C stated when a resident's medication(s) were discontinued, the nurse was supposed to pull the medication(s) from the medication cart and place the medication(s) in the locked cabinet in the medication room until the medications were properly destroyed. Both the DON and Licensed Staff C stated the nurse had a one-hour window before or after the routine medication was scheduled to be given. A review of the facility policy/procedure titled, Administering Medications, revised 12/12, indicated: #7 - The individual administering the medication must check the label three times to verify the right resident, right medication, right dose, right time and right route of administration before giving the medication. A review of the facility policy/procedure titled, Discontinued Medications, undated, indicated: #3 Discontinued medications must be destroyed or returned to the issuing pharmacy in accordance with established policies.

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.