STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056328	A. BUILDING _____ B. WING _____	04/27/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PREMIER CARE CENTER FOR PALM SPRINGS	2990 EAST RAMON ROAD PALM SPRINGS, CA 92264

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 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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure controlled medications (medications that require special handling according to federal and state law) were consistently and accurately recorded for one of three sampled residents (Resident A) when removed, administered, and disposed of. This failure increased the potential for medication errors and for drug diversion (obtain a substance for illegal or personal use). Findings: On February 13, 2020, at 1:09 p.m., and February 14, 2020, at 3:34 p.m., the Department received two linked complaints with allegations regarding Resident A's controlled medications given for pain. On February 28, 2020, at 11 a.m., an unannounced visit was made to the facility for the investigation of the two linked complaints. On February 28, 2020, beginning at 11:25 a.m., Resident A's record was reviewed and indicated Resident A was readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The physician's orders [REDACTED]. On February 28, 2020, at 12:40 p.m., Licensed Vocational Nurse (LVN) 1 was interviewed and stated the nurses were supposed to document controlled medications on the MAR and the narcotic sign-out sheets. On March 26, 2020, beginning at 1:18 p.m., Resident A's record was further reviewed. The physician's orders [REDACTED]. The .Narcotic and Antibiotic Drug Record form (controlled medication form used by nursing staff to record each dose of controlled medication removed from package), dated December 28, 2019, was reviewed concurrently with Resident A's Medication Administration Record (MAR), dated January 2020, and indicated the following: -On January 1, 29, and 30, 2020, doses of [MEDICATION NAME] were signed out on the controlled medication form, and there was no documented indication those doses were administered to Resident A on the MAR, and -On January 27, 2020, one dose documented as given to the resident on the MAR was not signed out on the controlled medication sign out form. The physician's orders [REDACTED]. The Controlled Liquid Drug Record form (controlled medication form used by nursing staff to record each dose of medication removed from vial), dated December 28, 2019, was reviewed concurrently with Resident A's MAR. There were multiple discrepancies that included the following: -On January 1, 2020, at 9:50 a.m., a dose of [MEDICATION NAME] liquid was recorded as wasted (disposed of) on the controlled medication sign out form, and was not witnessed by two licensed nurses when disposed of as required, -doses of [MEDICATION NAME] liquid were removed on January 3, 6, 8, and 9, 2020, and there was no documented indication that the doses were administered to Resident A on the MAR, and -On January 11, 2020, a dose of [MEDICATION NAME] was signed out at 8:30 a.m., and recorded as given almost one hour later at 9:20 a.m., on the resident's MAR. The physician's orders [REDACTED]. The .Narcotic and Antibiotic Drug Record form, dated December 28, 2019, was reviewed concurrently with Resident A's MAR and indicated the following: -On January 6, 2020, a dose of [MEDICATION NAME] was recorded as drop (dropped while removing or preparing medication) and was not witnessed by 2 licensed nurses when disposed of as required, -On January 1 and 22, 2020, doses of [MEDICATION NAME] were signed out on the controlled medication form and there was no documented indication those doses were administered to the resident on the MAR, and -doses of [MEDICATION NAME] on January 2 and 6, 2020, times and dates did not match on the controlled medication sign out form and the MAR. The controlled medications forms were further reviewed and indicated: -there was no documented date when remaining 22 doses of [MEDICATION NAME] were disposed of, -there was no documented date when 4 doses of [MEDICATION NAME] were disposed of, -there was no documented date when [MEDICATION NAME] liquid 1 milliliter was disposed of, -there was no documented date when [MEDICATION NAME] liquid 2 vials of 30 milliliters were disposed of, -there was no documented date when [MEDICATION NAME] 44 doses liquid was disposed of, and -there was no documented quantity disposed of for [MEDICATION NAME] liquid on controlled medication form dated January 30, 2020. On April 3, 2020, at 1:16 p.m., the Assistant Director of Nursing (ADON) was interviewed and stated controlled medications were kept in a locked box and the nurses had keys. The ADON stated the nurses were supposed to sign the controlled medication sign out form when the medication was removed, and the MAR when the medication was given to the resident. The ADON stated the times on the narcotic sign out form and MAR should be the same. The ADON stated controlled medications no longer being used by the resident were kept in the narcotic box and counted until the Director of Nursing (DON) retrieved them for disposal. The ADON stated the DON and pharmacist disposed of controlled medications and were supposed to sign and date the controlled medication form at the time the medications were disposed of. The facility policy and procedure titled, Medication Administration-Controlled Medications last revised May 2007, was reviewed and indicated, .When a controlled medication is administered, the licensed nurse administering the medication immediately enters all of the following information on the accountability record .date and time of administration, amount, signature of the nurse administering the dose after the medication is actually administered .When a controlled medication is removed from the container for administration but refused .or not given .it must be destroyed in the presence of two licensed nurses and the disposal documented on the accountability record .Any discrepancy .is reported to the Director of Nursing immediately .Controlled medications remaining in the facility after the order has been discontinued are retained .in a securely locked area .until destroyed . by the Director of Nursing .and pharmacy consultant .
F 0760 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure nursing staff held medication according to the physician's order for one of three sampled residents (Resident A) when Resident A's blood pressure was below ordered parameters. This failure increased the potential for harm for Resident A to experience adverse effects of the medication. Findings: On February 13, 2020, at 1:09 p.m., and February 14, 2020, at 3:34 p.m., the Department received two linked complaints with allegations regarding Resident A's controlled medications given for pain. On February 28, 2020, at 11 a.m., an unannounced visit was made to the facility for the investigation of the two linked complaints. On February 28, 2020, beginning at 11:25 a.m., Resident A's record was reviewed and indicated Resident A was readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The History and Physical, dated January 11, 2020, indicated Resident A had the capacity to make decisions. The Physician's Order, dated January 31, 2020, indicated Resident A was ordered to have [MEDICATION NAME] 3.125 milligrams, one tablet once a day in the morning to treat high blood pressure. The Order indicated the medication was to be held if Resident A's blood pressure was below 110 systolic (top number indicates pressure in blood vessels when heart pumps blood) or 60 diastolic (lower number indicates pressure when vessels relaxed) readings. On March 26, 2020, at 1:18 p.m., Resident A's Medication Administration Record [REDACTED]. On April 3, 2020, at 1:16 p.m., the Assistant Director of Nursing (ADON) was interviewed and stated if a resident was ordered to have a medication with specified parameters, the nurses were supposed to check the resident's blood pressure and heart rate before giving the medication. The ADON stated the medication should be given based on the parameters and if the blood pressure or heart rate checks were outside of the parameters, the nurses should hold (not give) the medication and document it. The facility policy and procedure titled, Medication Administration-Oral Medications last revised May 2007, was reviewed and indicated,

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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F 0760 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) It is the policy of this facility to accurately prepare. (sic) Administer, and document oral medications .read resident's medication sheet .take vital signs, if required .Hold drugs if indicated .