STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055296	A. BUILDING _____ B. WING _____	07/07/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
APPLEWOOD POST ACUTE	1090 RIO LANE SACRAMENTO, CA 95822

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 0624 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Prepare residents for a safe transfer or discharge from the nursing home.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a safe and orderly discharge from the facility for 1 of 3 sampled residents (Resident 1) by not conducting a medication reconciliation prior to Resident 1's discharge. This failure resulted in a dose of [MEDICATION NAME] (a prescription medication used to treat nerve pain and [MEDICAL CONDITION]), which was not prescribed for Resident 1, being administered to Resident 1 jeopardizing his health and safety. Findings: Resident 1 was admitted on [DATE] and subsequently discharged on [DATE] with mutiple [DIAGNOSES REDACTED]. In a record review of the document titled, Licensed Nurses Progress notes dated 1/30/20 at 6:36 p.m., a Licensed Nurse (LN) wrote Writer gave meds and went over MAR (medical administration record, a list of current resident medications) with resident father. Paperwork signed by father of resident. Record review of the document titled, Resident 1's Post-Discharge Plan of Care dated 1/30/20 revealed, the medication area of the document was blank. The facility was unable to provide any further documentation indicating a medication list including administration instructions was provided to resident or the responsible party upon discharge for Resident 1. During the concurrent interview and record review with Resident 1's Caregiver (CG) on 2/28/20 at 3:10 p.m., the CG stated a bubble pack of medication which had another resident's name on the medication label was inside the medication bag provided during discharge of Resident 1 from the facility. The CG stated the discharge paperwork provided did not include a copy of the Physician Orders and further stated the medications were not reviewed upon discharge so she was unaware the medication was not to be given to Resident 1. The CG stated that [MEDICATION NAME] 600 mg (milligrams, a unit of measure) was accidently given to Resident 1 by the CG before realizing the medication label had another person's name on it. The CG sent two photographs of the medication label on the bubble pack and verified the name on the package was not that of Resident 1. The CG stated that Resident 1 was not currently prescribed [MEDICATION NAME] by Resident 1's Physician. During a concurrent interview and record review on 3/2/20 at 3:10 p.m., Licensed Nurse 1 (LN1) stated medication orders are reviewed with the resident, responsible party (RP), or family as part of the discharge process and then a copy is kept on the medical record with the facility. On 3/2/20 at 3:50 p.m. in a concurrent interview and record review, the Medical Records Director confirmed Resident 1 did not have a copy of any medication discharge paperwork within the medical record. During an interview and record review on 3/26/20 at 11:40 a.m., Licensed Nurse 2 (LN 2) stated during the discharge process the LN should pull the medication list from the chart and check against the medication bubble packet being given to the resident/responsible party (RP) which includes ensuring the name, medication dose, and Physician Order match to ensure errors do not occur. LN 2 stated the medication list is signed and a copy is given to the resident/RP whereas the original is kept in the medical record at the facility. In a record review of the document titled, Discharge Census dated 3/2/20 indicated, the name on the medication label was from Resident 2 who had the same room assignment as Resident 1. The document noted Resident 2 discharged on [DATE]. On 3/27/20 at 1:50 p.m. during an interview, the Director of Nursing (DON) stated the expectation for discharging a resident is a LN would have printed out Physician's Orders and checked the medication bubble packs against the orders to ensure all medication information is correct. The LN should have obtained a signature from the resident/RP on the order sheet indicating medications were received and placed a copy of that document in the medical record. The expectation for LNs if a medication is not taken by a resident/RP on discharge is to remove the medication from the medication cart, take it to the medication room, log it in, and lock it up until the destruction of the medication is completed. The DON stated the expectation is the resident or RP had been provided the Physician Order sheet, Post Discharge Plan of Care on discharge, and a signed copy of both would have be kept in medical file to show this medication reconcliation process had occurred. The DON confirmed it is expected a LN compare the medication bubble packs against the Physician Orders for accuracy which would have included the resident's name, medication name, dosage, and route. The DON further stated the expectation was a LN would never send a medication out of the facility which was from another resident. A review of the facility policy titled, .DISCHARGE WITH MEDICATIONS dated 5/18/2018 indicated, Medications are sent with resident upon discharge from the facility only under conditions that protect the resident and assure compliance with applicable state laws. Within the Procedures section of the policy was written DISCHARGE WITH MEDICATION FORM .should be completed by facility and resident and/or responsible party prior to discharge. The policy revealed, Reconciliation: Facility must verify the accuracy of prescription labels against current Medication Administration Record [REDACTED].

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.