STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555153	A. BUILDING _____ B. WING _____	**03/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ESKATON CARE CENTER FAIR OAKS	**11300 FAIR OAKS BLVD. FAIR OAKS, CA 95628**

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 have an adequate system in place for providing pharmaceutical services that would identify, address, and prevent a medication error for 1 of 3 sampled residents (Resident 1), when the physician wrote an order for [REDACTED]. Findings: A review of Resident 1's clinical record indicated in late 2018, Resident 1 was admitted with [DIAGNOSES REDACTED]. Resident 1 scored 13 out of 15 in a Brief Interview for Mental Status (BIMS), which indicated mild cognitive impairment. A review of Resident 1 clinical records titled, Physician order [REDACTED]. The order was not clearly written nor was it a complete order because it did not include an indication as to why the [MEDICATION NAME] was prescribed. During an electronic record review of Resident 1's active physician orders, dated 1/7/2020, indicated LN 1 misinterpreted the physician's original order and entered [MEDICATION NAME] 500 mg, 2 tabs (total of 1000 mg), 3 times a day for 7 days. The pharmacy dispensed the medication as ordered in the computer without reviewing the physician's original written order. During a review of Resident 1's clinical records titled, Medication Administration Record [REDACTED]. On 1-10-2020 the order was changed to [MEDICATION NAME] 500 mg 1 tab TID. Per staff, clarification of MD prescription was for [MEDICATION NAME] 500 mg 1 tab and a nurse transcribed the original in error due to unfamiliar SNF (Skilled Nursing Facility) RX (Pharmacy Prescription) format. Pharmacy did not receive the original prescription and received the transcribed order. Resident received [MEDICATION NAME] 500 mg 2 tabs TID X 3 days . During an interview on 1/24/2020 at 4:03 p.m., the Unit Supervisor (US 1) stated LN 1 asked him to clarify the physician's original order. The US 1 said he also misinterpreted and verified the order as Amoxicillian 500 mg, 2 tabs (total of 1000 mg), 3 times a day for 7 days. US 1 confirmed this was a medication error because the dosage was misinterpreted from the original order due to the way the order was written. During an electronic record review of Resident 1's discontinued physician orders [REDACTED]. LN 1 confirmed she made the mistake when she misinterpreted and entered the medication order into the computer. LN 1 also stated she asked for clarification of the order and it was verified by US 1. LN 1 confirmed she did not call the physician for clarification of the order. During an interview on 1/31/2020 at 5:08 p.m., the Director of Nursing (DON) stated on 1/10/2020, US 1 requested for her to look over the original physician order [REDACTED]. The DON said the physician should have written the medication order more clearly, per facility policy. The DON confirmed the physician's orders [REDACTED]. The DON also stated the pharmacy was notified of the error and the medication was discontinued and reordered correctly. A review of the facility's policy titled, Medication Orders Non-Controlled Medication Orders, dated 2007, indicated Policy- medications are administered only upon the receipt of a clear, complete and signed order by a person lawfully authorized to prescribe . comply with applicable formularies or prescribing protocols that have been provided to the nursing care center by the responsible physician .Elements of the Medication Order: 1. Medication orders must include the following specifics: a. Residents Name b. Date c. Name of medication d. Strength of the medication, where indicated, e. Dose and dosage form f. Time or frequency of administration g. Route of administration h. Quantity or duration (length) of therapy, when applicable. If not specified by prescriber on a new order, the duration may be limited by automatic stop order policy. i. Indication for use if ordered PRN or as needed j. Any other state or federal requirements 2. Any dose or order that appears inappropriate, considering the resident's age, condition, allergies [REDACTED]. Documentation of the Medication Order: 1. Care should be taken to avoid errors or misinterpretation of handwritten information. Particular attention must be given to how medication names and strengths are expressed when writing medication orders .New Orders Transmit the appropriate copy of the order to the pharmacy for dispensing.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE