STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055330	A. BUILDING _____ B. WING _____	08/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ADVANCED REHAB CENTER OF TUSTIN	**2210 E. FIRST STREET SANTA ANA, CA 92705**

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, medical record review, and facility document review, the facility failed to ensure two prescribed medications were administering as ordered for one of two sampled residents (Resident 2). * Resident 2 did not receive [MEDICATION NAME] or [MEDICATION NAME] medications as ordered on [DATE]. This posed the risk of Resident 2 not receiving the therapeutic effect of the prescribed anti-psychotic and mood stabilizing medications. Findings: According to the facility's P&P titled Medication Administration, General Guidelines dated October 2017 showed the routine medications are to be administered within one hour before and up to one hour after the scheduled time. Medical Record Review for Resident 2 was initiated on 7/16/2020. Resident 2 was admitted to the facility on [DATE], and discharged on [DATE]. Review of Resident 2 physician's history and physical examination [REDACTED]. On 7/16/20 at 1017 hours, a telephone interview was conducted with Resident 2. Resident 2 stated she did not receive her routine medications of [MEDICATION NAME] 300 mg and [MEDICATION NAME] 600 mg from facility staff on 6/19/20. Resident 2 stated she was to have received both medications at 2100 hours. Resident 2 stated the medication nurse told her the medications were unavailable at the time. Resident 2 stated she did receive [MEDICATION NAME] and [MEDICATION NAME] the next night. Resident 2 stated these two medications helped treat her [MEDICAL CONDITION] disorder and depression and not receiving the medication caused her to feel anxious. She stated this made her feel like she could not trust the facility to provide the care she needed. Review of Resident 2's plan of care identified had a care plan for the use of the [MEDICAL CONDITION] medications, [MEDICATION NAME] and [MEDICATION NAME]. The goal was for Resident 2 to be and remain free of [MEDICAL CONDITION] drug related complications. The intervention stated to administer the [MEDICAL CONDITION] medications as ordered by the physician and monitor for side effects and effectiveness every shift. Review of Resident 2's physician's orders [REDACTED].* 6/27/20, [MEDICATION NAME] 200 mg tablet by mouth once daily at bedtime for [MEDICAL CONDITION] manifest by increased agitation * 6/27/20, [MEDICATION NAME] 600 mg tablet by mouth daily at bedtime for [MEDICAL CONDITION] disorder Review of Resident 2's MAR for June 2020 showed Resident 2 received [MEDICATION NAME] 200 mg and [MEDICATION NAME] 600 mg every evening at 2100 hours daily from 6/12/20 to 6/18/20, however, these medications were not administered on 6/19/20. Staff documented 9 and according to the Chart Codes, 9 meant Other / See Progress Notes. Review of the Resident 2's Progress Notes dated 6/19/20, documented by LVN 1, identified [MEDICATION NAME] 200 mg and [MEDICATION NAME] 600 mg were not available and the pharmacy was called. There was no documentation the resident's physician was notified of the missed doses. On 7/16/2020 at 1606 hours, an interview and concurrent medical record review for Resident 1 was conducted with the DON. The DON was informed of the above findings. The DON verified Resident 2's [MEDICATION NAME] and [MEDICATION NAME] were not administered on 6/19/20 as ordered. The DON stated, the expectation was for residents' medications to be administered as ordered. The DON stated a medication that need to be refilled should be reordered 3 days prior to the last dose of the medication remaining. The DON stated when a medication was not available or a dose was missed, the expectation was the licensed nurse would contact the pharmacy for a STAT refill and notify the resident's physician. The DON verified there was no documentation to show Resident 2's physician was notified and there was no order to hold the medications. On 7/17/2020 at 1112 hours, a telephone interview was conducted with LVN 1. LVN 1 stated he had taken care of Resident 2 on 6/19/20 during the evening shift (1500-2300 hours). LVN 1 stated Resident 2's [MEDICATION NAME] and [MEDICATION NAME] medications were not in the medication cart and therefore, he did not administer these medications to Resident 2 on 6/19/20. LVN 1 stated he informed Resident 2 he was not able to administer [MEDICATION NAME] or [MEDICATION NAME] that evening. LVN 1 stated Resident 2 became upset and worried about missing her schedule medications. LVN 1 stated he called the pharmacy and documented this in Resident 2's progress notes. LVN 1 stated he did not speak with Resident 2's physician but had left a message with the physician's service; however, he did not document it. LVN 1 stated the resident's medications should not have been missed as [MEDICATION NAME] and [MEDICATION NAME] treated Resident 2's psychological disorders. LVN 1 stated the pharmacy did deliver Resident 2's [MEDICATION NAME] and [MEDICATION NAME] after his shift had ended.

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