

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555147	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2025
NAME OF PROVIDER OR SUPPLIER Oak River Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 3300 Franklin Street Anderson, CA 96007	
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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41715</p> <p>Based on Interviews and record review, the facility failed to meet this requirement when Resident 1 was administered nitroglycerin without a physician ' s order. This was against the facility ' s policy and had the potential to contribute to a decline in Resident 1 ' s health.</p> <p>Findings</p> <p>Resident 1 was admitted to the facility on [DATE] for diagnoses that included metabolic encephalopathy, (an imbalance of chemicals in the blood that can cause confusion and tiredness), morbid (life-threatening) obesity, muscle weakness, congestive heart failure (inability of the heart to return blood flow to the body), history of stroke, and hypertension (high blood pressure).</p> <p>Review of the facility ' s policy titled Administering Medications, revised April 2019, indicated that physician orders are required for administering medications to residents:4. Medications are administered in accordance with prescriber orders .</p> <p>A review of the facility ' s policy titled Medication Orders, dated 11/2014, indicated that: 2. A current list of orders must be maintained in the clinical record of each patient.</p> <p>Review of the facility ' s policy titled, Adverse Consequences and Medication Errors, dated 2/23, indicated that a medication error is defined as the preparation or administration of drugs or biologicals which is not in accordance with physician ' s orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services.</p> <p>The policy further indicated that examples of medication errors could include, b., Unauthorized Drug - a drug is administered without a physician ' s order.</p> <p>The policy indicated that an adverse consequence refers to an unwanted, uncomfortable, or dangerous effect that a drug may have.</p> <p>Review of the facility ' s record titled Medication Deviation Report dated 11/19/24, indicated that on 11/19/24, Licensed Vocational Nurse (LVN C) administered nitroglycerine to Resident 1 without a physician ' s order, and that Resident 1 was transferred to emergency room for a higher level of care. The record indicated that corrective action was taken and that LVN C was terminated.</p> <p>(continued on next page)</p>		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 555147	Facility ID: 555147 If continuation sheet Page 1 of 3

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 1 ' s Change of Condition report dated 11/19/24 at 1:53 PM, indicated that at approximately 1:00, Resident 1 complained of chest pain to the left side and that he couldn ' t breathe, and that Resident 1 received two doses of nitroglycerine five minutes apart. During that time, the record indicated Resident 1 ' s blood pressure dropped from 102/64 to 60/40. The report indicated that Resident 1 ' s physician was notified, and Resident 1 was transferred to a nearby medical center at approximately 1:30.</p> <p>Review of a signed document provided by LVN C (undated), indicated that LVN C confirmed that she gave Resident 1 two doses of nitroglycerin, five minutes apart, without an order, and that Resident 1 was sent to an acute care hospital because his blood pressure had dropped from 102/64 to 69/44.</p> <p>In an interview on 1/16/25 at 10:20 AM, Director of Nursing (DON A) confirmed that the facility had become aware of the error, that LVN C had administered nitroglycerine to Resident 1 without having a physician ' s order, and that Resident 1 had experienced a drop in blood pressure afterward. DON A stated that LVN C was then terminated for not following the facility ' s policy. DON A indicated that the facility had already begun its plan of correction by holding an inservice for nursing staff reminding them of the requirements to obtain a physician ' s order. Concurrent review of a record titled Inservice Sign-in Sheet dated 11/26/24 indicated 21 participants had attended.</p> <p>In an interview on 1/16/25 at 11:25 AM, LVN D confirmed that it is the facility ' s policy to administer medications only with a physician order, and that the physician is readily available to give verbal orders in emergency situations.</p> <p>In an interview on 1/16/25 at 12:15 PM, Medical Director E confirmed that he had not given an order to LVN C for the nitroglycerine.</p> <p>Based on Interviews and record review, the facility failed to meet this requirement when Resident 1 was administered nitroglycerin without a physician's order. This was against the facility's policy and had the potential to contribute to a decline in Resident 1's health.</p> <p>Findings</p> <p>Resident 1 was admitted to the facility on [DATE] for diagnoses that included metabolic encephalopathy, (an imbalance of chemicals in the blood that can cause confusion and tiredness), morbid (life-threatening) obesity, muscle weakness, congestive heart failure (inability of the heart to return blood flow to the body), history of stroke, and hypertension (high blood pressure).</p> <p>Review of the facility's policy titled Administering Medications, revised April 2019, indicated that physician orders are required for administering medications to residents:4. Medications are administered in accordance with prescriber orders .</p> <p>A review of the facility's policy titled Medication Orders, dated 11/2014, indicated that: 2. A current list of orders must be maintained in the clinical record of each patient.</p> <p>Review of the facility's policy titled, Adverse Consequences and Medication Errors, dated 2/23, indicated that a medication error is defined as the preparation or administration of drugs or biologicals which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services.</p> <p>(continued on next page)</p>		

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