STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555221	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Surprise Valley Community Hospital D/P Snf	741 N. Main Street Cedarville, CA 96104

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40204 Based on interview and record review, the facility failed to follow policy requirements of the facility policy titled, Weight Assessment & Interventions for one of twelve residents sampled by not reweighing Resident 13 (R13) when weight loss was discovered. The failure to follow the policy requirement affected one resident creating the potential for additional unaddressed weight loss and a detrimental clinical outcome for residents. Findings: The facility policy titled, Weight Assessment & Interventions was reviewed. Under the policy section titled, Weight Assessment numeral 3 states, Any weight change of 5 pounds more or less since the last weight assessment will be retaken the next day for confirmation. According to the policy, over 3 months a weight loss of greater than 7.5% is significant. Resident 13 was admitted on [DATE] with diagnoses that included Alzheimer disease. On 4/15/2025 at 10:30 AM, during a concurrent interview with the Director of Nursing (DON) and record review of weight documentation for Resident 13 (R13) was performed. The documented weight on 2/2/2024 was 132 pounds. The weight on 3/3/2024 had dropped to 125 pounds for a total loss of 7 pounds. The recorded weight loss was more than required for a reweigh. The DON provided documentation of weights for R13 and stated that, The weight should have been retaken for March (3/3/24) because it was more than 5 pounds per policy. The DON confirmed, There should be another weight for the next day on the sheet (Vital Signs Grid). The CNA's (Certified Nursing Assistants) do the weights and write them in. They should have done it again the next day. During an interview with CNA 3 on 4/17/2024 at 3:30 PM, CNA 3 stated, The residents are weighed on Sundays. If they are below 5 pounds from the last time, we weight them again on Mondays. There aren't many. When asked if R13 would have been reweighed on 3/3/2024, CNA 3 stated, If we know we do it. On 4/18/2024 at 8:15 AM CNA 4 was interviewed regarding reweighing residents. CNA 4 stated, We get the weights and when they are not right we reweigh then. Sometimes it is the chair. We weigh them first then the chair after and subtract. If there is blankets it can make it wrong. CNA4 was not aware resident 13 needed reweighed on 3/3/2024.

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 41715 Based on interview, observation and record review, the facility failed to meet this requirement when a medication for one (Resident 10) of nine sampled residents did not match Resident 10's current physician order, and did not meet professional pharmacy standards of practice for drug labeling. This resulted in the potential for overdosing medication and harm to the resident. Findings: Resident 10 was admitted to the facility in November, 2019 and was recently being treated with the antibiotic Sulfametoxazole/trimethoprim (SMZ/TMP or Septra) for a urinary tract infection. Review of the facility's policy titled, ER Medication Dispensing and Prescribing, revised 4/6/24, indicated that Medications to be dispensed will be unit dose whenever possible . [Unit dosing is the pharmacy practice of providing no more or no less medication than will be administered to the resident to lessen the risk of under or overdosing]. A review of the facility's record titled, prescribing order dated 7/22/22, indicated that the facility's physician ordered 400 millligrams (a unit of measure) of sulfamethoxazole/80 milligrams of trimethoprim in a single dose. In an observation on 4/16/24 at 11:00 AM, Licensed Vocational Nurse (LVN 1) was observed taking Resident 10's medication from a blister pack (pre-packaged medication doses in individual plastic bubbles on a multi-dose card) labeled SMZ/TMP DS TAB 800/160, indicating 800 milligrams of sulfamethoxazole, 160 milligrams of trimethoprim tablets. The tablets were provided in a form that was double the dose to be administered to Resident 10, requiring the nurse to split the tablet in half, therefore the medication was not unit dosed per pharmacy policy. The package was not labeled by pharmacy with the new dose, and handwriting in blue ball point pen indicated, 1/2 tablet, 400mg/80mg. In an interview on 4/16/24 at 1:32 PM, Director of Nursing (DON) stated that staff cannot re-label medications on the blister pack; pharmacy must label all medications. DON stated that it is not an acceptable practice to re-write dose changes by handwritten instructions. In a telephone interview on 4/16/24 at 1:00 PM, Pharmacy Consultant (PC) stated that the facility's blister pack medication is designed to be dose-specific and contain the dose to be delivered to the resident to avoid medication errors, and that the best practice is for pharmacy to provide a pharmacy-printed label according to the current dose. PC stated that only pharmacy technicians or pharmacists can re-label medications and red alert stickers are to be used to note dosing changes.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 40204 Based on observation, interview, and record review, the facility failed to submit the required Payroll Based Journaling (PBJ), staffing information to the Centers for Medicare and Medicaid Services (CMS). The failure to submit the required data, staffing hours and census information, can prevent determining whether or not an adequate level of staff is working at a given time, leading to inadequate care of residents and adverse clinical outcomes. Findings: On 04/18/24 at 10:10 AM, the PBJ reporting data was reviewed with the Facility Administrator (FA). FA stated, I am not sure who is doing it. It maybe the Director of Nursing (DON). The DON was present and stated, I believe it is done in payroll. It is not nursing that has that information. Human Resources was also present and added that, It is not being done in HR. On 04/18/24 at 10:15 AM, the PBJ reporting data was reviewed with the Accounting Clerk (AC). AC stated, We don't submit this. I think it is nursing. I have not done it before. There was no evidence offered by the facility that the facility was in compliance with submitting the PBJ data and report to CMA, as required by regulation.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 41715 Based on interview and record review, this regulation was not met when the facility failed to have a program in place to prevent an outbreak by testing their water for legionella bacteria, (Legionaire's Disease, a potentially fatal lung infection). This had the potential for residents, staff and visitors to become infected with legionella bacteria and cause illness and possibly death. Findings: In an interview and concurrent record review on 4/15/24 at 1:23 PM, Maintenance Manager (MM) provided the facility's water testing logs from a professional testing laboratory. MM stated that he was unaware of a requirement to test for or prevent legionella. Review of a record titled Analytical Report water monitoring dated 2/5/24, indicated that testing was done for coliform and e. Coli (two bacteria from sewage that can be present in water), but legionella testing was absent. MM confirmed that legionella was not listed on the vendor's report of tests performed on the water. Similarly, a contracted laboratory's microbiology testing report for the facility, dated 2/2/24 did not indicate testing for legionella. Similarly, review of a record titled, County Water District report 2022 indicated no legionella testing was performed at the municipal source of the facility's water. In an interview on 4/17/24 at 1:30 PM, Facility Administrator (FA) stated that she was unaware of requirement for Legionella/Management and water testing or that this was required by the Centers for Medicare and Medicaid Services (CMS). In a follow-up interview and concurrent record review on 4/17/24 at 11:35 AM, MM stated that he will develop a written plan for legionella prevention and can add testing to current water testing being done by a lab for the facility.