

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055761	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/15/2024
NAME OF PROVIDER OR SUPPLIER  Encinitas Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  900 Santa Fe Drive Encinitas, CA 92024	

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)
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39220</b></p> <p>Based on observation, interview, and record review, the facility failed to administer six out of 14 medications ordered by the physician for a total of eight days for one of three residents (Resident 1) reviewed for significant medication error.</p> <p>As a result, Resident 1 did not receive medications as ordered by a physician and there was no treatment provided for diagnosed health conditions. Resident 1 was at risk for worsening breathing problems, increased blood pressure, increased heart rate, and possible stroke from blood clot formation.</p> <p>Findings:</p> <p>On 3/25/24, an unannounced visit was made to the facility regarding three complaints related to medication errors which involved one resident (Resident 1).</p> <p>Resident 1 was admitted to the facility on [DATE], with diagnoses to include cancer in the right lung and Pneumonia in the left lung, per the facility 's Admission Record.</p> <p>On 3/25/24 at 10:45 A.M., an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated when Resident 1 was admitted , the licensed nurse (LN 2) who processed Resident 1 ' s admission paperwork did not enter Resident 1 ' s physician orders into the computer system. As a result, some of the medications had not been administered. The ADON stated they realized the error, eight days later when Resident 1 was sent to the hospital for radiation treatment. The ADON stated the facility performed a thorough investigation of Resident 1 ' s admission process.</p> <p>On 3/25/24, Resident 1 ' s clinical record was reviewed.</p> <p>Resident 1 had a Durable Power of Attorney (DPOA-a person selected by the resident to make health care decisions on resident ' s behalf.)</p> <p>According to the initial hospital discharge summary, Resident 1 had Pneumonia (an infection in the lungs), and a new onset of atrial fibrillation (an irregular and often rapid heart beat.) The resident was to start on new medications after arriving at the Skilled Nursing Facility. The new medications included Prednisone (a steroid used for the inflammation in the lungs), Amiodarone (a medication that works directly on the heart to maintain a normal heart rhythm, and Apixaban (used to prevent blood clots from forming).</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
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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>The previous admission orders, dated 3/7/24 and the Medication Administration Record (MAR) from 3/7/24 through 3/15/24, were provided by the ADON for review.</p> <p>The facility ' s Progress Notes were reviewed, dated 3/15/24 at 9:10 P.M. LN 3 documented, Went to Radiology around 3:30 P.M., Later received call from DPOA, resident admitted to (name of hospital) for pneumonia, sepsis (infection in the blood) rapid A-fib (atrial fibrillation) heart rate of 180-200 (beats per minute) PET scan (positron emission tomography-an imagining test that uses radioactive material to diagnose diseases) to r/o (rule out) stroke, facial drooping.</p> <p>The facility ' s documented vital signs (blood pressure, heart rate, respiratory rate) were reviewed from 3/7/24 through 3/15/24:</p> <p>The blood pressure ranged from 106/63 (lowest on 3/9/23) to 135/77 (highest on 3/13/24). On 3/15/24 prior to leaving the facility, the blood pressure was 131/69.</p> <p>The heart rate ranged from 70 (lowest on 3/13/23) to 111 (highest on 3/11/24). On 3/15/24 prior to leaving the facility the heart rate was 108 beats per minutes.</p> <p>The respiratory rate ranged from 17 (lowest on 3/7/24 and 3/10/24) to highest 20 (highest on 3/8/24 and 3/14/24). On 3/15/24 the respiratory rate was 18 breaths per minute.</p> <p>On 3/25/24 at 11:15 A.M., an observation of Resident 1 in her room was conducted. Resident 1 was sitting straight up in bed with oxygen being delivered to her nose via a nasal cannula (plastic flexible tube that administers oxygen to the nose from an oxygen machine). Resident 1 was short of breath, and non-verbal. A home caregiver and the resident ' s significant other were sitting next to the resident.</p> <p>On 3/25/24 at 11:25 A.M., an interview was conducted with Licensed Nurse 1 (LN 1). LN 1 stated when residents arrive for admission, the LN was required to orient the resident ' s and their family to the facility, conduct a head-to-toe assessment, review their medication orders, and enter them into the computer system, then develop care plans based on the resident ' s medical condition. LN 1 stated if the medications were not entered into the computer system, they would not appear on the Medication Administration Record (MAR), so the medication nurses would not know the medications were supposed to be given. LN 1 continued, stating medications for the heart and to thin out the blood were very important and could cause medical complications to the resident, if not administered as ordered by the physician.</p> <p>On 3/25/24 at 11:39 A.M., an interview and record review was conducted with LN 2. LN 2 stated she had been at this facility since August 2023, and has admitted over 30 residents before this incident. LN 2 reviewed the admission orders and the MAR from 3/7/24 through 3/15/24. LN 2 stated Resident 1 ' s admission orders were written differently than she was used to seeing. LN 2 stated she later learned she had missed entering some of Resident 1 medications into the computer system, after the resident was sent to the hospital on 3/15/24. LN 2 stated she thinks one of the medication pages must have gotten stuck to the first medication page, and that was the reason she missed some of the medications into their computer system.</p> <p>(continued on next page)</p>		

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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>LN 2 reviewed the medication listed and the MAR. LN 2 stated Resident 1 was supposed to have received a total of 14 medications, and she only received eight of those medications from 3/7/24, until she went to the hospital on 3/15/24. LN 2 stated Resident 1 missed the following medications:</p> <p>Cardizem 180 milligrams (mg), 1 tablet once a day for Arial Fibrillation</p> <p>Escitalopram 10 mg, tablet once a day for depression</p> <p>Prednisone 10 mg, tablet once a day for pneumonia for a total of 10 days</p> <p>Protonix 40 mg, tablet once a day for gastric/esophageal reflex disease (GERD)</p> <p>Amiodarone 200 mg, one tablet, twice a day for atrial fibrillation</p> <p>Apixaban 5 mg, one tablet, twice a day for atrial fibrillation</p> <p>LN 2 stated she manually checked off the medications on the first page of the admission orders as she was entering them, which was her usual practice, and no check marks were found on the second page of medications. LN 2 stated since she did not enter those six medications into the computer system, and the medications were never ordered or entered on the MAR, and the other staff were unaware they should have been given. LN 2 stated Resident 1 ' s lungs and breathing problems could have worsened, her blood pressure could have been elevated along with her heartrate, and she could have had suffered a stroke.</p> <p>On 3/25/24 at 12:01 P.M., a record review was conducted of LN 2 ' s employee file. LN 2 had completed a competency assessment upon hire and had no disciplinary actions in her file.</p> <p>On 3/25/24 at 12:05 P.M., a follow-up interview was conducted with the ADON. The ADON stated because Resident 1 missed the medications, she could have had a stroke, increased infection in her lung, and an elevated heartrate. The ADON stated she was relieved Resident 1 did not experience any lasting ill-effects from the medications omitted.</p> <p>On 3/27/24 at 9:46 A.M., an interview was conducted with the facility ' s pharmacist (Pharm). The Pharm stated she was notified of Resident 1 ' s medications not being administered. The Pharm stated by not administering the Cardizem, it could have affected the resident ' s atrial fibrillation which could include an increased heartrate. The Pharm stated Prednisone should never be stopped suddenly, but the new order was never started so the only harm was the resident could have had a worsening of the pneumonia and increased inflammation to the lung tissues. The Pharm stated by Resident 1 not receiving her two atrial fibrillation medications, she could have had increased risk of blood clotting, leading to a stroke and a prolonged recovery process. The Pharm stated the medications were never entered into the system, so they were never delivered by the pharmacy, and they were unaware of the order.</p> <p>(continued on next page)</p>

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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>On 3/27/24 at 1:09 P.M., an interview was conducted with Resident 1 ' s Medical Doctor (MD 1). MD 1, stated with Resident 1 not receiving the Prednisone for lung inflammation, it was difficult to say what could have occurred, and he could not speculate what the harm could have been. MD 1 stated by not receiving the Cardizem, Resident 1 ' s heart rate could have increased and by not receiving the two atrial fibrillation medication, she could have formed a blood clot. MD 1 stated he examined Resident 1 and could not identify any ill-effects or long-term injury from missing the medications.</p> <p>According to the facility ' s policy, titled, Admission of a Resident, undated, .1 . b. Once the resident or family has selected the facility .iii. Physician ' s orders, iv. Medications and/or treatment record, .2. Upon admission the designated facility staff will obtain information and perform assessments as per their respective departments and as per facility protocol .</p>