STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555323	A. Building B. Wing	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aviara Healthcare Center	944 Regal Road 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)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36765 Based on interview and record review, the facility failed to ensure that Resident 1 received only medications prescribed for him. This failure had the potential for Resident 1 to have an adverse reaction to the incorrect medications administered. Findings: Resident 1 was admitted to the facility on [DATE] with diagnoses that included chronic congestive heart failure (the heart does not pump blood effectively); chronic respiratory failure (lungs can ' t exchange gases properly); and Marfan Syndrome (a disorder that affects connective tissue) per the facility ' s Admission Record. There was no psychiatric diagnosis. No observational opportunity was available for Resident 1 as he had been discharged from the facility. On 1/25/24 at approximately 5 P.M., Resident 1 was administered two (2) 200 milligram (mg) tablets of Seroquel (a medication used to treat psychiatric disorders). An interview was conducted on 4/4/24 at 9:30 A.M. with the director on nursing (DON). The DON stated, The medication was given by a registry (temporary agency) nurse. Another resident ' s medication card (a card with the Resident ' s name, medication and dosage prepared by the pharmacy) was mixed in with Resident 1 ' s medication cards. The registry nurse did not look at the card and just gave it (the medication) to him. She assumed it was his because it was with his other medication cards. Seroquel 400 mg is a high dose and can cause side effects. Resident 1 became drowsy. An interview was conducted on 4/4/24 at 11:40 A.M. with licensed nurse (LN) 1. LN 1 is a medication nurse (a nurse who administers medications to facility residents). LN 1 stated, I always check to make sure the medication card has the correct resident ' s name, medication and dosage. The registry nurse was unavailable for interview as she was no longer contracted by the facility. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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	A review of the facility ' s policy, dated, 4/2019, titled Administrating Medications, indicated, Policy Statement: Medications are administered in a safe and timely manner, and as prescribed .Policy Interpretation and Implementation: 4. Medications are administered in accordance with prescriber orders .9. The individual administering the medication checks the label THREE times to verify the right resident, right medication, right dosage, right time and right route of administration before giving the medication .25. Medications ordered for a particular resident may not be administered to another resident .