STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555585	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Shores Post-Acute	2828 Meadowlark Drive San Diego, CA 92123

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48270 Based on interview and record review, the facility failed to accurately transcribe an admission order for an intravenous (IV-medication given through a vein) antibiotic for one of three residents (Resident 1). This failure had the potential to result in a medication error for Resident 1. Findings: Resident 1 was admitted to the facility on [DATE] with diagnoses of sepsis (serious condition in which the body responds improperly to an infection) and pyomyositis (bacterial infection of the skeletal muscle). Per the nursing admission assessment record, dated 2/13/24, Resident 1 was transferred from another facility with medication orders to continue at the admitting facility. A review of Resident 1 ' s physician ' s orders from the transferring facility, dated 2/6/24, included an order for Ertapenem 1 g (gm; gram) IV Q24H (every 24 hours). A review of Resident 1 ' s admission physician ' s orders, dated 2/13/24, included an order for Ertapenem 1 GM - Inject 1 gram intramuscularly (injection administered deep into the muscle) one time a day. On 3/8/24 at 11:21 AM, a concurrent interview and record review with the Assistant Director of Nursing (ADON) was conducted. The ADON stated that before a new admission arrived at the facility, a report from the nurse at the transferring facility was given to a nurse at the receiving facility. The ADON stated that he was the nurse who received the report from the transferring hospital for Resident 1. The ADON stated the report included two IV antibiotics to be administered to Resident 1, once a day: Ertapenem 1 gram and Daptomycin 500 milligram. A review of Resident 1 ' s admission orders indicated that the admitting nurse transcribed an order for Ertapenem 1 GM - Inject 1 gram intramuscularly one time a day. However, a review of the transferring facility discharge orders indicated the order was for Ertapenem 1 g IV Q24H. The ADON stated that this inaccurate transcription could have resulted in a medication error. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555585	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER The Shores Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 2828 Meadowlark Drive San Diego, CA 92123	

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/8/24, at 11:45AM, a concurrent interview and record review with Registered Nurse 1 (RN 1) and the Director of Nursing (DON) was conducted. RN 1 stated that he was the nurse who transcribed the admitting orders for Resident 1. When asked why the Ertapenem was ordered as an intramuscular injection and not intravenously as written in the discharge orders, RN 1 stated he did not know how it was changed. RN 1 stated that it is important for residents to receive the right medications, especially IV antibiotics. A review of the facility policy titled, Admission Assessment and Follow Up: Role of the Nurse, dated September 2021, indicated that the nurse is responsible for reconciling the list of medications from the medication history, admitting orders .and the discharge summary from the previous institution.