

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555739	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/17/2024
NAME OF PROVIDER OR SUPPLIER The Springs at Pacific Regent		STREET ADDRESS, CITY, STATE, ZIP CODE 3884 Nobel Drive San Diego, CA 92122	

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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48270</p> <p>Based on interview and record review, the facility failed to ensure one medication (med) was administered per physician ' s order for one resident (2). Resident 2 ' s Insulin Lispro (med to control high blood sugar) was administered via injection, and not via insulin pump (medical device that supplies a continuous flow of insulin subcutaneously [beneath the skin]), as ordered.</p> <p>As a result, Resident 2 ' s blood sugar level dropped below a normal range. This failure had the potential to affect Resident 2 ' s health, comfort, and well-being.</p> <p>FINDINGS:</p> <p>Resident 2 was admitted to the facility on [DATE] with diagnoses which included diabetes type 1 (DM 1 - high blood sugar; body produces very little insulin - hormone that lowers the level of sugar in the blood), end stage renal disease (permanent kidney failure) and cirrhosis of the liver (severe scarring of the liver).</p> <p>A review of Resident 2 ' s medical records were conducted.</p> <p>The Order Summary Report, dated 4/1/2024, indicated Resident 2 had an order for Insulin Lispro Injection 100 UNIT/ML (unit per milliliters) - Inject 40 unit [sic] subcutaneously one time a day for DM1 via insulin pump.</p> <p>The Medication Administration Record (MAR), dated 4/2/2024, included documentation that licensed nurse (LN) 1 administered 40 units of Insulin Lispro at 9 a.m.</p> <p>A progress note dated 4/2/2024, included documentation that Resident 2 ' s blood sugar was 26, and upon being rechecked, the blood sugar was 24 (DM 1 normal blood sugar range is between 80 and 130). Per this record, the LN referenced the MAR and documented that Resident 2 had been administered an incorrect insulin dosage at breakfast time .</p> <p>On 4/16/2024, at 12 p.m., an interview was conducted with LN 3. LN 3 stated that Resident 2 ' s insulin was administered incorrectly on 4/2/2024. LN 3 stated that LN 1 administered 40 units of Insulin Lispro via injection with a syringe, but should have administered (the Insulin Lispro) via Resident 2 ' s insulin pump.</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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(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>On 4/16/2024, at 12:20 p.m., an interview was conducted with LN 1. LN 1 stated she was the nurse who administered medications to Resident 2 on 4/2/2024. LN 1 stated she did not know what an insulin pump was. LN 1 stated she should have double checked and asked another nurse instead of administering the insulin incorrectly.</p> <p>On 4/16/2024, at 1 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated that all medications must be administered as ordered by the physician, to ensure resident safety. The DON acknowledged that LN 1 administered the insulin incorrectly and that the physician 's order was not followed.</p> <p>A review of the facility undated policy titled, Medication Administration, indicated that Medications must be administered in accordance with the written orders of the attending physician.</p>		