STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555915	A. BUILDING _____ B. WING _____	**09/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE SPRINGS HEALTH AND REHABILITATION CENTER	**25924 JACKSON AVE MURRIETA, CA 92563**

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 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure for one of three sampled residents (Resident A), received care consistent with professional standards of practice when a licensed staff failed to properly verify the resident's information and the physician's orders [REDACTED]. This failure resulted in the wrong administration of the eye drop medication to Resident A. Findings: On August 5, 2020, an unannounced visit to the facility was conducted to investigate a complaint related to quality of care concerns. On August 5, 2020, at 10:04 a.m., Resident A was interviewed and stated one of the licensed nurses administered the wrong eye drop medication at night. She stated she knew her medications very well and she told the nurse it was the wrong medication since she recognized a different color of the eye drop bottle. Resident A's record was reviewed. Resident A was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The history and physical, dated June 30, 2020, indicated Resident A had the capacity to understand and make decisions. A physician's orders [REDACTED]. A physician's orders [REDACTED]. The progress notes, dated July 23, 2020, at 11:09 p.m., indicated, Res (resident) with an order of Latanoprost at bed time 2100 (9:00 p.m.). Writer accidentally (gave) [MEDICATION NAME] 0.5% to res left eye. Washed the left eye with water three times . No complain of pain or discomfort. (Name of physician) made aware and said, 'It will be ok let's monitor .' On August 5, 2020, at 12:30 p.m., the Director of Nursing (DON) was interviewed regarding Resident A and stated Registered Nurse (RN) 1 administered the wrong medication to Resident A on July 23, 2020. She stated RN 1 administered the eye drop medication that belonged to another resident. She stated RN 1 should have checked the right medication and right patient before administering the medication. On September 3, 2020, at 12:50 p.m., RN 1 was interviewed regarding Resident A and stated Resident A was alert and oriented and was aware of her medications. She stated she grabbed the wrong eye drop medication and failed to verity with the physician's orders [REDACTED]. She stated she failed to verify the resident and the medication prior to administration. The facility's policy and procedure titled, Medication Administration-General Guidelines, dated January 2017, was reviewed and indicated, .Medications are administered as prescribed in accordance with good nursing principles and practices . Prior to administration, the medication and dosage schedule on the resident's Medication Administration Record [REDACTED]. Medications are administered in accordance with written orders of the attending physician . Residents are identified before medication is administered using (two) methods of identification . Checking identification band . Checking photograph attached to medical record . Verifying resident identification with another nurse . According to the Foundations and Adult Health Nursing, Seventh Edition, authored by Cooper and Gosnell, Copyright 2015, it indicated: SIX 'RIGHTS' OF MEDICATION ADMINISTRATION .The nurse must use each step of the nursing process when carrying out responsibilities pertaining to medication administration. Medications are administered in a variety of ways. Regardless of the route by which a drug enters the body, the same practices and principles of medication administration apply. .The nurse should follow the six rights of medication administration each time he or she must administer a medication . Right medication . Right dose . Right patient . Right time . Right route . Right documentation . RIGHT MEDICATION .The nurse should make sure the drug to be given is the correct drug, and performs the three label checks: checking the label on the drug's container three times-before, during and after preparation . Check the label when taking the medication from where it has been stored . Check the label before removing the medication from its container . Check the label before discarding or replacing the medication container and before giving the medication to the patient. RIGHT PATIENT The nurse should give the right medication to the right patient. The nurse can prevent medication errors by systematically identifying the patient before administering medication. There are several ways to do this, and the nurse should follow the facility's policy. The nurse should check the patient's identification bracelet to validate his or her name and date of birth, and then the nurse should ask the patient his or her name and date of birth . Safety Tips for Medication Administration Listen to the patient. Listening to the patient can be a mechanism for preventing medication errors. If the patient says that he or she does not take a certain medication when preparing to administer the medication, refer to the Medication Administration Record [REDACTED].

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

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.