STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056401	A. BUILDING _____ B. WING _____	**03/25/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MISSION HILLS POST ACUTE CARE	**3680 REYNARD WAY SAN DIEGO, CA 92103**

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** Based on interview and record review, the facility failed to ensure one resident (1) was free of significant medication (med) errors, when Resident 1 received meds that were not ordered by her physician. This failure subjected Resident 1 to potential side effects and harmful med interactions. Findings: Resident 1 was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record. A review of the facility's Unusual Occurrence Report, dated 10/17/17 was conducted. This report included documentation that on 10/11/17 at approximately 4 A.M., Resident 1 was mistakenly administered the following meds that were ordered for another resident (2): [MEDICATION NAME] (for pain) 8 milligrams (mg) and [MEDICATION NAME] (for pain) 30 mg. An interview was conducted on 10/13/17 at 11:30 A.M. with the director of nursing (DON). The DON stated that the licensed nurse (LN) 1 who administered the meds to Resident 1 was not a regular staff nurse at the facility. The DON stated LN 1 was a registry nurse (nurse who was employed by an agency to work on a as needed basis). Upon review of Resident 1's record titled, Order Summary Report, dated April 2017 through October 2017, there were no physician orders for Resident 1 to be administered [MEDICATION NAME] and [MEDICATION NAME]. According to the facility's policy titled Medication Administration, revised May 2007, It is the policy of this facility to accurately prepare. Administer and document. 2. Administer drug to resident. A. Identify resident. B. Check identification band. D. Verify with another staff member if any question in the above. 3. Read resident's medication sheet. Essential Points: 1. No medication is to be administered without a physician's written order.7. The resident must be identified before administering medication. In an interview with the DON on 10/13/17 at 1:30 P.M., the DON stated the med error occurred when LN 1 did not accurately identify the resident and the meds before she administered the meds to Resident 1. The DON acknowledged the [MEDICATION NAME] 8 mg and [MEDICATION NAME] 30 mg were administered to Resident 1 without physician's orders.

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.