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 _____	**05/13/2020**

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 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure licensed nursing staff followed professional standards of practice for two of three sampled residents (Resident A and B) when medications were not given on time and with documented parameters. These failures increased the potential medication errors and for medications to not be given as ordered and scheduled. Findings: On February 19, 2020, at 1:10 p.m., an unannounced visit was made to the facility for the investigation of three linked complaints regarding quality of care and staffing concerns. On February 19, 2020, beginning at 2:40 p.m., Resident A's record was reviewed and indicated Resident A was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The History and Physical, dated January 14, 2020, indicated Resident A could make her needs known but not make medical decisions. The physician's orders [REDACTED].two times a day [MEDICAL CONDITION] if SBP is less than 110 or pulse is less than 60 ([MEDICATION NAME] one tablet twice a day for high blood pressure-hold the dose if systolic blood pressure less than 110 or heart rate less than 60 when checked immediately before dose given). The physician's orders [REDACTED]., shoulders, and hands for pain. Resident B's record was reviewed and indicated Resident B was admitted to the facility February 4, 2020, with [DIAGNOSES REDACTED]. The History and Physical, dated February 6, 2020, indicated Resident B did not have the capacity to make decisions. The physician's orders [REDACTED].Apply to back topically in the morning for pain management . at 9 a.m. daily. On March 25, 2020, at 9:55 a.m., Resident A and B's records were further reviewed. Resident A's Medication Administration Records (MAR)s, dated January and February 2020, had no documented indication of Resident A's blood pressure and heart rate checks before the dose of [MEDICATION NAME] was given for all 39 doses in January, and 5 doses in February, 2020. The MARs indicated Resident A's [MEDICATION NAME] Gel, for pain, was given more than one hour late, eight times on the morning shift in January , and twelve times in February, 2020. The latest dose was given to Resident A more than 3 hours past the time it was due. Resident A's Care Plan, dated January 22, 2020, indicated Resident A was at risk for pain, and had interventions that included administer [MEDICATION NAME] (pain medication) as ordered. Resident B's Mars indicated Resident B's [MEDICATION NAME] Patch, for pain, was given more than one hour late, eight times in February 2020, with the latest dose given 4 hours and 5 minutes past the time it was due. On April 02, 2020, Resident A and B's records were further reviewed. Resident a's Care Plan, dated January 23, 2020, indicated Resident A had a history of [REDACTED]. The Care Plan indicated interventions that included, . take vital signs as ordered. Notify physician of abnormal readings . Resident B's Care Plan, dated February 5, 2020, indicated Resident B was at risk for pain , and included interventions, .Anticipate resident's need for pain relief and respond immediately . On April 02, 2020, at 10:52 a.m., the Director of Nursing (DON) was interviewed and stated if a resident had medication orders with parameters , the nurses were supposed to check the resident's blood pressure and heart rate before the medication was given, and document on the MAR. The DON stated if the resident's medication was ordered to be given at 9 a.m. daily, the nurses were supposed to give the medication between 8 and 10 a.m. The facility policy and procedure, titled, Medication-Administration last revised July 1, 2016, was reviewed and indicated, .Purpose .To provide practice standards for safe administration of medications .The licensed nurse must know the following information about any medication they are administering .indication for use .any precautions .medications may be administered one hour before or after scheduled administration time .taking of vital signs upon which medications are conditioned will be performed as required and the results recorded .
F 0836 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure employee personnel (HR) files were complete and had required information readily accessible for 4 of 5 sampled HR files. This failure increased the potential for employees caring for residents to not have current and verified licensure, certifications, and/or identification in place. Findings: On February 19, 2020, at 1:10 p.m., an unannounced visit was made to the facility for the reinvestigation of three linked complaints with allegations regarding staff competencies and quality of care issues. On February 19, 2020, beginning at 4:20 p.m., a sample of five employee HR files were reviewed and indicated the following: -Certified Nursing Assistant (CNA) 1 had a hire date of [DATE], and there was no copy of CNA 1's current CNA certification, or CPR certification (cardio-pulmonary resuscitation-standard emergency life-saving measures) in the file, -Licensed Vocational Nurse (LVN) 1 had a hire date of [DATE], and there was no copy of LVN 1's current nursing license or CPR certification in the file, -Registered Nurse (RN) 1 had a hire date of [DATE], and there was no documentation of RN 1's identification including driver's license and social security number (SSN), and no copy of RN 1's current nursing license or CPR certification in the file, and -LVN 2 had a hire date of [DATE], and there was no copy of LVN 2's current nursing license, CPR certification or identification in the file. On February 19, 2020, the Director of Staff Development (DSD) was interviewed and stated she had multiple stacks of loose employee records and would need to search to see if the facility had the copies of licenses, CPR certificates, and ID's that were missing from the sampled HR files listed above. During a concurrent record review, a copy of LVN 2's nursing license was found in the stack of forms that indicated the license was last verified on [DATE], and expired [DATE]. The DSD could not find copies of LVN 2's identification. The DSD stated nursing licenses and certifications were supposed to be verified on hire and when the licenses or certifications were renewed. According to Title 22, CCR, , .all licensed nurses shall have training in cardiopulmonary resuscitation . and CCR , .Each facility shall maintain current complete and accurate personnel records for all employees .The record shall include .Full name .Social Security number .Professional license .Such records shall be retained for at least three years following termination of employment .

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