STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055286	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kearny Mesa Convalescent and Nursing Home	7675 Family Circle Drive San Diego, CA 92111

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a medication was administered as ordered, and to ensure unattended medications were not accessible to residents for one of five sampled residents (1). As a result, Resident 1 had an increased risk of pain from the missed medication, and residents were at risk of accidental ingestion or exposure to unattended medications left on the floor.Findings: Per the facility's admission Record, resident 1 was admitted to the facility on [DATE] with diagnoses to include anxiety. Per the facility's Progress Notes, there were no notes documented for Resident 1 on 3/11/26. Per the facility's Progress Note dated 3/12/26 at 9:45 A.M., the Director of Nursing (DON) documented, Visited with resident at bedside earlier this morning, regarding medications from last night.Resident handed 2 capsules which pt (patient) states are her [pregabalin] (a pain medication) and gabapentin (a pain medication) Per the facility's Controlled Drug Record for Resident 1, dated 3/19/26, one dose of pregabalin was signed as given from the package on 3/11/26 at 9 P.M. There were no further doses taken from the package that night after the initial 9 P.M. dose. On 3/24/26 at 12:29 P.M., an interview was conducted with Resident 1. Resident 1 stated, one morning she found her medications on the floor and realized she had not taken all of them the previous night. On 4/2/26 at 11:28 A.M., a telephone interview was conducted with Licensed Nurse (LN) 2. LN 2 stated, on 3/11/26 she had prepared the 9 P.M. medications for Resident 1, then dropped the medications on the floor and was not able to find them. LN 2 further stated, that she then reprepared Resident 1's medications, but forgot to include the pregabalin, so that medication was not administered. LN 2 stated, she should have asked for help finding the dropped medications at the time of the incident. On 4/3/26 at 12:38 P.M., a telephone interview was conducted with the DON. The DON stated, LN 2 should have doublechecked the orders before administering Resident 1's medications, and she should have searched for the dropped medications. Per the facility's policy, titled Administering Medications, revised April 2019, Medications are administered in accordance with prescriber orders

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