

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055322	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2024
NAME OF PROVIDER OR SUPPLIER The Pavilion at Ocean Point		STREET ADDRESS, CITY, STATE, ZIP CODE 3202 Duke Street San Diego, CA 92110	

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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49330</p> <p>Based on observation, interview and record review, the facility failed to ensure medication orders for two of 3 sampled residents (Resident 1 and Resident 2) were administered as ordered.</p> <p>This failure had the potential to affect Resident 1 and Resident 2's health and safety.</p> <p>Findings:</p> <p>1. Resident 1 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included muscle weakness, fracture of right femur head, unsteadiness on feet according to the facesheet.</p> <p>A review of Resident 1's physician's orders, dated 2/2/2024, indicated Resident 1 was to receive Lidocaine gel 4% topically (on the skin) every morning.</p> <p>On 4/18/2024 at 7:30 A.M., a medication administration observation was conducted for Resident 1's morning medications. Lidocaine gel 4% was not administered to Resident 1 by licensed nurse (LN) 1.</p> <p>On 4/18/2024 at 11:07 A.M., an interview was conducted with Resident 1 in his room. Resident 1 stated he does not remember receiving lidocaine gel every morning.</p> <p>On 4/18/2024 at 11:35 A.M., a joint interview and record review was conducted with LN 1. LN 1 stated Resident 1's lidocaine gel 4% should have been administered to the resident per physician's order. A joint record review was done conducted with LN 1. There was no documentation of physician notification. LN 1 stated that if the medication was unavailable, a progress note should have been entered and the physician should have notified.</p> <p>2. Resident 2 was admitted to the facility on [DATE] with diagnoses that included osteoarthritis (a bone infection) according to the facesheet.</p> <p>A review of Resident 2's physician's orders, dated 12/1/2023, indicated Resident 2 was to receive 4 lidocaine patches 4% to the lower back and 1 lidocaine patch 4% to the neck and cervical spine every morning.</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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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 2's medication administration record (MAR) for April 2024 indicated lidocaine patch 4% was not given on 4/16, 4/17, and 4/18. The MAR indicated that the lidocaine patch was not given on 4/16 because it was refused by Resident 2. The MAR indicated that the lidocaine patch was held on 4/17. The MAR indicated that the lidocaine patch was not given because it was unavailable on 4/18.</p> <p>A review of Resident 2's nursing progress notes did not indicate that the physician was notified of the lidocaine patches not being given to Resident 2 for 3 days.</p> <p>An interview with licensed nurse (LN) 1 was conducted on 4/18/2024 at 11:35 A.M LN 1 stated the lidocaine patches should have been given to Resident 2 as ordered. LN 1 stated if the lidocaine patches were not given as ordered, the physician should have been notified and a progress note entered in Resident 2's chart. LN 1 stated it was important to enter a progress note so the resident's condition will be known by the staff.</p> <p>An interview with the Director of Nursing (DON) was conducted on 4/18/2024 at 11:50 A.M. The DON stated that it was her expectation for staff to follow the physician's orders. The DON acknowledged that if the physician's orders were not followed, the physician should be notified, and it should be documented in the resident's chart.</p> <p>A review of the facility policy titled Medication-Administration, revised on January 2012, indicated, . Medication will be administered directly by a Licensed Nurse and upon the order of a physician .Whenever a medication is held for any reason, the licensed nurse will document on the MAR. Licensed Nurse will notify the M.D. and document in the medical record.</p>		