STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055322	A. Building B. Wing	08/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Pavilion at Ocean Point	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)
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** 48270 Based on interview and record review, the facility failed to ensure medications were administered as ordered by the physician for two residents (1, 2). Resident 1 was administered Ativan (medication to relieve anxiety) 0.5 milligrams (mg) more times than what the physician ordered. For Resident 2, Cefazolin (medication to treat an infection) 2 grams (gm) was ordered to be administered intravenously (IV; method of administering medication into a vein), every eight hours, but was not administered on four separate times as the IV therapy was ordered. These failures had the potential to affect Resident 1 and Resident 2's well-being and health. Findings: 1. Resident 1 was admitted to the facility on [DATE] with diagnoses that included anxiety disorder, per Resident 1's face sheet. On 6/28/24, a review of Resident 1's clinical record was conducted. Resident 1's physician's orders, dated June 2024 included an order dated 1/31/24 for Ativan 0.5 mg, give 0.5 mg by mouth in the afternoon for anxiety. Upon review of the Controlled Drug Record, dated June 2024, this record included documentation that Resident 1 was administered Ativan more than once a day on the following dates: 6/7/24 at 6 A.M. and at 5:01 P.M. 6/16/24 at 6 A.M. and at 11 P.M. On 6/28/24 at 2 P.M., an interview was conducted with the Director of Nursing (DON). The DON acknowledged that physician's orders were not followed when Resident 1 was adminsitered the Ativan. The DON stated it was her expectation that all nurses followed the physician's orders as ordered. 2. Resident 2 was admitted to the facility on [DATE] with diagnoses that included osteomyelitis (bone infection) of the left foot, per Resident 2's history and physical record. On 7/19/24, a review of Resident 2's clinical record was conducted. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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	Resident 2's physician's orders dated June through July 2024 included an order dated 6/12/24 for Cefazolin 2 gm, Use 2 grams intravenously every eight hours for bacterial infection until 7/14/24. Upon review of Resident 2's Medication Administration Record dated July 2024, the Cefazolin was not administered on the following dates and times: 7/3/24 at 2 P.M. 7/6/24 at 10 P.M. 7/7/24 at 6 A.M. 7/9/24 at 2 P.M. On 7/19/24, at 3 P.M., an interview was conducted with the Director of Nursing (DON). The DON acknowledged that Resident 2 was not administered the IV antibiotic every eight hours as ordered. The DON stated that this was not acceptable and that it was her expectation that all nurses followed the physician's orders as ordered. The facility policy titled Medication-Errors, dated July 2018 indicated, Medication errors means the administration of medication .at the wrong time .at the wrong dose .