STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055328	A. Building B. Wing	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Care Center	5602 University Ave San Diego, CA 92105

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40610 Based on interview and record review, the facility failed to implement a care plan (detailed plan with information about a patient's treatment, goal, and interventions) related to medication administration for one of three sampled residents (Resident 1). This failure had the potential to not meet the goals of treatment and needs of Resident 1. Findings: On 1/28/25 at 1:57 P.M., an unannounced onsite to the facility was conducted related to a complaint on Nursing Services. Resident 1 was admitted to the facility on [DATE], with diagnoses which included hypothyroidism (underactive thyroid gland), per the facility's Admission Record. On 1/28/25, a review of Resident 1's physician order dated 12/19/24 indicated the following order: - Levothyroxine 1 tablet at 6 AM. On 1/28/25, a review of Resident 1's care plan related to levothyroxine administration indicated one of the interventions was to administer medication as ordered. On 1/28/25 at 3:15 P.M., a joint review of Resident 1's medication administration record (MAR, used to document medications taken by each patient) and an interview with Licensed Nurse (LN) 1 was conducted. The MAR for 12/20/24 through 1/1/25 was reviewed with LN 1. The MAR for administration of levothyroxine for Resident 1 indicated the following entries: - 12/20/24 at 8:24 A.M. - 12/22/24 at 8:31 A.M - 12/24/24 at 8:37 A.M. - 12/27/24 at 8:29 A.M. (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

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LN 1 stated levothyroxine was ordered to be administered at 6 A.M. and should be given on an empty stomach or before breakfast. On 1/28/25 at 3:45 P.M., a joint review of Resident 1's MAR and care plan, and an interview with the Director of Nursing (DON) was conducted. The DON stated the medication should be given one hour before and one hour after the scheduled time. The DON stated the care plan should have been followed and implemented. A review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, revised March 2022, indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .9. Care plan interventions are chosen only after data gathering .careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making .

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NAME OF PROVIDER OR SUPPLIER University Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5602 University Ave San Diego, CA 92105	

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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 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** 40610 Based on interview and record review, the Licensed Nurses (LNs) failed to administer Levothyroxine (a medicine used to treat an underactive thyroid gland [hypothyroidism]) within the time frame as ordered by the physician for Resident 1. This failure had the potential to negatively affect Resident 1's absorption of the medication and had the potential for ineffective medication. Findings: On 1/28/25 at 1:57 P.M., an unannounced onsite to the facility was conducted related to a complaint on Nursing Services. Resident 1 was admitted to the facility on [DATE], with diagnoses which included hypothyroidism, per the facility's Admission Record. On 1/28/25, a review of Resident 1's physician order dated 12/19/24, indicated the following order: - Levothyroxine 1 tablet at 6 AM. On 1/28/25 at 3:15 P.M., a joint review of Resident 1's medication administration record (MAR, used to document medications taken by each patient) and an interview with Licensed Nurse (LN) 1 was conducted. The MAR for 12/20/24 through 1/1/25 was reviewed with LN 1. The MAR for administration of levothyroxine for Resident 1 indicated the following entries: - 12/20/24 at 8:24 A.M. - 12/22/24 at 8:31 A.M - 12/24/24 at 8:37 A.M. - 12/27/24 at 8:29 A.M. LN 1 stated levothyroxine was ordered to be administered at 6 A.M. and should be given on an empty stomach or before breakfast. LN 1 stated she did not know the reason it should be given on an empty stomach or before breakfast. LN 1 stated the medication should be given before her shift. LN 1 stated, I will get back to you. On 1/28/25 at 3:45 P.M., a joint review of Resident 1's MAR and an interview with the Director of Nursing (DON) was conducted. The DON stated the expectation was for the LNs to give the medication on time, an hour before and one hour after. It is important to follow because there might be medical reason behind it. (continued on next page)

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy titled, Administering Medications, revised April 2019, indicated, Medications are administered in a safe and timely manner, and as prescribed .4. Medications are administered in accordance with prescriber orders, including any required time frame. 5. Medication administration times are determined by resident need and benefit .Factors that are considered include: a. enhancing optimal therapeutic effect of the medication; b. preventing potential medication or food interaction .