

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055890	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/24/2024
NAME OF PROVIDER OR SUPPLIER Magnolia Post Acute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 635 S Magnolia Ave El Cajon, CA 92020	
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** 47466 Based on interview and record review, the facility failed to follow their own policy regarding receipt of narcotics (controlled substance) for 1 of 2 sampled residents. This failure occurred when a licensed nurse did not check or inventory medications which included narcotics delivered by the pharmacy to the facility. As a result, the whereabouts of Resident 1's narcotic medication was not known. This deficient practice had the potential to delay pain medication administration, could affect residents ' safety and created an opportunity for drug diversion. Findings: Resident 1's record was reviewed. Per the undated facility Admission document, Resident 1 was admitted to the facility on [DATE] with diagnoses that included hemiplegia and hemiparesis (partial paralysis on one side of the body) and stiffness of bilateral ankles. A record review on 5/21/24 was conducted. Per the facility's document titled: Packing Slip Proof of Delivery, dated 5/16/24, LN 3 signed for receipt of 30 tablets of Hydroco/Apap-5-325mg (Norco) for Resident 1. Resident 1 was interviewed on 5/21/24 at 10:30 A.M. Resident 1 stated he requested Norco (a narcotic pain medication) on 5/18/24 at around 12 P.M. Resident 1 stated, the Licensed Nurse 1 (LN1) said the medication was not available because the facility had to reorder the pain medication from the pharmacy. Resident 1 stated pain medication was administered from the facility ' s emergency kit. An interview on 5/21/24 at 10:45 A.M., with LN1 was conducted. LN1 stated licensed staff must check the pharmacy bag and make sure everything was accounted for and keep a record on the delivery receipt. LN 1 stated narcotics were ordered usually 2-3 days ahead of time before the medication was exhausted. An interview with LN 2 was conducted on 5/21/24 at 11:05 A.M. LN 2 stated medications delivered should be reconciled with the pharmacy delivery manifest. LN 2 stated licensed staff must take everything delivered from pharmacy out of the bag to make sure we have everything. The next step is for the licensed staff to compare with the pharmacy delivery manifest and then sign for them. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 055890	Facility ID: 055890 If continuation sheet Page 1 of 2

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A phone interview with LN 3 was conducted on 5/22/24 at 4:24 P.M. LN 3 stated she did not check each medication from the bag delivered from the pharmacy (on 5/16/24) but did sign for everything delivered from pharmacy. LN 3 stated she should have checked the bag from the pharmacy before she signed the manifest to make sure every medication was there. LN 3 stated the facility policy was to have a licensed nurse to check and sign for receipt of medications including narcotics. A joint record review and interview was conducted on 5/22/24 with the Director of Nursing (DON). Review of: Policy / Procedure -Nursing Clinical revised 5/20/2024 .#5 A second person licensed nurse will cosign the narcotic count sheet and delivery manifest upon receipt of controlled medication from pharmacy. The DON stated two licensed nurses should have checked and signed for Resident 1's delivered medications, including narcotics from the pharmacy. A phone interview with the Pharmacist (PH) was conducted on 5/23/24 at 8:30 A.M. The PH stated according to the manifest, Resident 1's narcotic medication (Hydroco/Apap 5-325 mg, 30 tabs) was delivered to Resident 1's facility and was received and signed out by the facility ' s licensed nurse, (LN 3) on 5/16/24. The PH then stated, later another facility had called the pharmacy and reported possession of Resident 1's narcotic medication. The PH stated Resident 1's narcotic medication had been returned to the pharmacy and was later found next to the refuse bin /pile. The PH stated the refuse/pile had not been checked for a few days. An interview with the Director of Nursing was conducted on 5/23/24 at 11:55 A.M. The DON stated on 5/18/24 the facility had initiated an audit of all medication carts, intravenous (medication delivered through a plastic tube to a vein) carts, treatment carts and medication rooms but was unable to locate Resident 1's narcotic medication. The DON stated licensed nurses should check one by one anything that comes from the pharmacy especially narcotic medications.		