STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056017	A. Building B. Wing	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Jolla Nursing and Rehabilitation Center	2552 Torrey Pines Rd LA Jolla, CA 92037

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** 39111 Based on interview and record review, the facility failed to ensure one of four residents' (Resident 3) routine medication was available to be administered to the resident. As a result, Resident 3 was not consistently administered her daily thyroid medication. Findings: A review of Resident 3's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses to include hypothyroidism (low thyroid hormones). A review of Resident 3's physician order dated 10/2/23, indicated the resident was to receive levothyroxine (thyroid medication) 125 micrograms, two tablets daily, that was scheduled to be given at 6:30 A.M. On 4/16/24 at 3:26 P.M., a telephone interview was conducted with Resident 3. Resident 3 stated, The pharmacy here's not good, refills and deliveries don't get done. Resident 3 stated during the first week of April (2024) there were four days she did not receive her levothyroxine. Resident 3 stated when she asked about the availability of her levothyroxine, the licensed nurse (LN) told her there was none. On 4/17/24 at 2:25 P.M., a joint interview and record review was conducted with LN 5. LN 5 stated he worked on 4/8/24 and went to administer Resident 3's levothyroxine at 6:30 A.M., and the medication had been unavailable. LN 5 stated he informed Resident 3 that her medication was unavailable, and the resident told him that she had not received her levothyroxine for four days. LN 5 reviewed Resident 3's medication administration record (MAR) and stated he documented by mistake that Resident 3's levothyroxine had been administered on 4/8/24. LN 5 stated Resident 3's medication had not been available to administer to the resident and the pharmacy had not delivered it yet. LN 5 stated Resident 3 should have received her levothyroxine as ordered. A review of the pharmacy receipts titled Consolidated Delivery Sheets indicated Resident 3's levothyroxine refill (a 30-day supply) had been delivered to the facility on [DATE]. Resident 3's previous levothyroxine refill (30-day supply) had been delivered on 2/27/24. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/17/24 at 3:30 P.M., an interview was conducted with the director of nursing (DON). The DON stated Resident 3's levothyroxine should have been available and administered to the resident as ordered. A review of the facility's policy titled Medication Orders updated August 2019, did not provide guidance related to availability of medications and administration as ordered.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39111 Based on observation, interview, and record review, the facility failed to ensure three of six residents' (Resident 1, 2, and 3) medications were stored securely when: -Resident 1's medications were observed at the resident's bedside. -Resident 2 and 3 reported their medications were left at their bedsides. These failures had the potential for residents to receive the wrong medication and/or incorrect dosage which may cause clinically significant adverse consequences. Findings: A review of Resident 1's Admission Record indicated the resident was admitted to the facility on [DATE]. A review of Resident 2's Admission Record indicated the resident was readmitted to the facility on [DATE]. A review of Resident 3's Admission Record indicated the resident was admitted to the facility on [DATE]. On 4/16/24 at 3:26 P.M., a telephone interview was conducted with Resident 3. Resident 3 stated her morning thyroid medication was often left at her bedside around 5 A.M., to take later when she woke up. On 4/17/24 at 10:27 A.M., an observation and interview was conducted with Resident 1 while inside the resident's room. There were four pills in a medicine cup on Resident 1's bedside table. Resident 1 stated the licensed nurse (LN) left the medications at his bedside this morning because he takes the pills slowly. On 4/17/24 at 11:09 A.M., an interview was conducted with Resident 2. Resident 2 stated there were times when her morning medications were left on her bedside table for her to take when she woke up. On 4/17/24 at 11:42 A.M., a joint observation in Resident 1's room and interview was conducted with LN 5. LN 5 observed the medications left at Resident 1's bedside. There were three pills inside Resident 1's medication cup: one round white pill, one oblong white pill marked ATV 40, and one yellow capsule marked 138 138. LN 5 stated the pills looked like vitamin C, atorvastatin (cholesterol lowering medication), and gabapentin (medication for pain). LN 5 stated atorvastatin was a medication given at night. LN 5 stated medications should not have been unsecured and left at the resident's bedside. LN5 further stated Resident 1 could have double dosed or missed a dose of medication. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 1's April 2024 medication administration record (MAR) indicated the resident's atorvastatin 40 mg was scheduled to be given at 9 P.M. The same MAR indicated Resident 1's atorvastatin had been administered on 4/1/24 and 4/8/24 and coded as refused 4/2/24 through 4/7/24 and 4/9/24 through 4/16/24. On 4/17/24 at 3:30 P.M., an interview was conducted with the director of nursing (DON). The DON stated medications should not have been left unattended at the residents' bedsides. The DON stated residents could have experienced adverse medication reactions, taken too much medication, not enough medication, or incorrectly administered the medication to themselves. A review of the facility's policy titled Medication Storage in the Facility updated August 2019, indicated, Medications and biologicals are stored safely, securely, and properly