| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056182 | A. Building<br>B. Wing | 08/28/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Golden Hill Post Acute | 1201 34th St.<br>San Diego, CA 92102 |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmacy services in accordance with accepted standards of practice when:1. A medication was not in stock for one of five sampled residents (Resident 5) when it was due. This failure had the potential for Resident 5 not to benefit from the full therapeutic effect of her medication. 2. Random controlled medication (medications with a high abuse potential) use audit for four out of eight sampled residents (Residents 6, 9, 37, 73) did not reconcile. The residents' medications were signed out of the controlled drug record (CDR, count sheet), but not documented on the Medication Administration Record (MAR) to indicate they were administered to the residents. This failure resulted in inaccurate accountability and had the potential for abuse and diversion (unlawful distribution or use) of controlled medications. 3. Controlled medications for pain were not administered as ordered for two of five sampled residents (Residents 72 and 73). This failure had the potential for Residents 72 and 73 to experience harmful effects and negative health outcomes from the controlled medications. 1. During the medication administration observation on 8/25/25 at 9:41 a.m., Licensed Nurse (LN) 2 was observed preparing and administering 11 medications for Resident 5. LN 2 stated she did not have Resident 5's twelfth medication, Vitamin D 5000 international units (IU, unit of measure), in stock. LN 2 stated she cannot give the Vitamin D pending pharmacy supply.We have different Vitamin Ds, but I can't give it to her because it's a different strength. LN 2 stated that the Vitamin D would not be coming in that day (8/25/25), although nursing staff told her it was ordered last Thursday (on 8/21/25). A review of Resident 5's clinical record indicated Resident 5 had an active order since 7/22/25 for Vitamin D3 (a type of Vitamin D) oral tablet 125 micrograms (mcg, unit of measure). Vitamin D 125 mcg is equivalent to Vitamin D 5000 IU. Give 1 tablet by mouth one time a day for Vit[[NAME]] D deficiency [low Vitamin D levels]. During an interview with the Director of Nursing (DON) on 8/27/25 at 8:59 a.m., the DON stated it is not acceptable for residents to be without their medications. The DON stated, They're taking their medications for a reason.A review of the facility's policy and procedure (P&P) titled, Medication Administration and Storage, revised 3/2025, indicated, .accurately prepare, administer and document medications as per physician's order.A review of the facility's P&P titled, Pharmacist, Services of a Licensed, revised 6/2025, indicated, The pharmacist is responsible for helping the facility obtain and maintain timely and appropriate pharmaceutical services that support residents' healthcare needs.1.including.accurate acquiring, receiving, dispensing, and administering of drugs.6. Strive to assure.medications are requested, received, and administered in a timely manner as ordered by the physician. 2. The CDRs for eight random residents receiving PRN (as needed) controlled medications were requested for review. a) A review of Resident 6's clinical record indicated she had an order for tramadol (a controlled medication used to relieve pain) 25 milligram (mg, unit of measure) tablet - give one tablet by mouth every 8 hours as needed for moderate to severe pain, dated 6/21/25. During a concurrent interview and record review with the DON on 8/27/25 at 8:06 a.m., a review of Resident 6's CDR for tramadol 25 mg and August 2025 MAR indicated the nursing staff signed out of the CDR but did not document the medication administration on four occasions: 8/4/25 at 6:47 a.m.<br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | and 9 p.m., 8/6/25 at 9:30 p.m. and 8/9/25 at 8:43 p.m. The DON confirmed this finding and stated, I'm missing the MAR documentation on this. There's no documentation on the MAR for tramadol on 8/4, 8/6 and 8/9. b) A review of Resident 9's clinical record indicated she had an order for oxycodone (a controlled medication and strong painkiller) 5 mg tablet - take one tablet by mouth every 6 hours as needed for severe pain, originally dated 6/24/25.During a concurrent interview and record review with the DON on 8/27/25 at 8:37 a.m., a review of Resident 9's CDR for oxycodone 5 mg and the August 2025 MAR indicated the nursing staff signed out of the CDR but did not document the medication administration on 6 occasions:8/3/25 at 4:08 p.m.8/8/25 at 9:02 p.m.8/9/25 at 6:45 a.m.8/21/25 at 9:37 p.m.8/23/25 at 8:36 p.m.8/24/25 at 8:50 p.m. The DON confirmed this deficiency and stated, I couldn't find that either, regarding any documentation on the MAR for oxycodone on 8/3, 8/8, 8/9, 8/21, 8/23 and 8/24. c) A review of Resident 73's clinical record indicated he had an order for oxycodone 5 mg, give one tablet by mouth every 6 hours as needed for moderate to severe pain, dated 6/21/25.During a concurrent interview and record review with the DON on 8/27/25 at 8:47 a.m., a review of Resident 73's CDR for oxycodone 5 mg and the July 2025 MAR indicated nursing staff signed the CDR but did not document on the medication administration on 1 occasion: 7/30/25 at 10 p.m. The DON confirmed this deficiency and could not find any documentation on the MAR on 7/30/25 for oxycodone.d) A review of Resident 37's clinical record indicated she had an order for hydrocodone-acetaminophen (a controlled medication and painkiller) 10/325 mg, give one tablet every 4 hours as needed for moderate to severe pain, dated 7/30/25. During a concurrent interview and record review with the DON on 8/27/25 at 8:47 a.m., a review of Resident 37's CDR for hydrocodone-acetaminophen 10/325 mg and the August 2025 MAR indicated nursing staff signed the CDR but did not document on the medication administration on 1 occasion: 8/24/25 at 8:47 p.m. The DON confirmed this deficiency. The DON stated, I don't see that one either.During an interview with the DON on 8/27/25 at 8:37 a.m., the DON confirmed controlled medication administration should be documented properly on the CDR and MAR. The DON stated improper documentation creates more room for errors. and increased risk of side effects for the residents. The DON stated controlled medications are tracked on a higher scale. If anything is missing, it could be a diversion and that's what we want to prevent. Even when we dispose it with the pharmacist, we make sure it's there. The DON stated, we need to know the exact administration for future administrations so we can track it appropriately and prevent diversion. A review of the facility's P&P titled, Controlled Medications, revised 6/2025, indicated, .6. When a controlled medication is administered, the licensed nurse administering the medication immediately enters all of the following information on the accountability record: Date and time of administration. Amount administered. Signature of the nurse administering the dose, completed after the medication is actually administered. 3. a) A review of Resident 72's clinical record indicated that she had an order for hydrocodone-acetaminophen 5/325 mg tablet, give one tablet by mouth every 6 hours as needed for severe pain (6-10 level pain out of 10, with 0 being no pain and 10 being the worst pain imaginable), originally dated 6/26/25. Resident 72 received doses, as documented on her July 2025 and August 2025 MARs, despite having a pain level less than 6 on the following dates:7/12/25 at 7:24 p.m. pain level 57/14/25 at 5:27 p.m. pain level 58/2/25 at 6:55 p.m. pain level 48/5/25 at 9:48 a.m. pain level 28/8/25 at 3:30 p.m. pain level 58/10/25 at 5:19 p.m. pain level 08/12/25 at 10:08 p.m. pain level 08/13/25 at 5:33 p.m. pain level 08/15/25 at 9:20 p.m. pain level 18/19/25 at 5:32 p.m. pain level 48/20/25 at 9:28 p.m. pain level 58/25/25 at 4:16 p.m. pain level 58/26/25 at 3:22 p.m. pain level 5During a concurrent interview and record review with the DON on 8/28/25 at 1:15 p.m., the DON confirmed the order was for severe pain (pain level 6-10). The DON also verified the entries on Resident 72's July and August 2025 MARs.A drug review of hydrocodone-acetaminophen on Daily Med (https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=e23d135c-7aea-405a-804e-5c4f82179e96, accessed 8/29/25), a drug resource site, updated 1/11/24, indicated side effects, such as dizziness, lightheadedness, nausea, vomiting and sedation. Signs and symptoms of overdose listed included (continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | respiratory depression (slow, shallow breathing), somnolence (excessive sleepiness), cold and clammy skin, low blood pressure, low blood sugar and coma. b) A review of Resident 73's clinical record indicated that he had an order for oxycodone 5 mg tablet, give one tablet by mouth every 6 hours as needed for moderate to severe pain (4-10 level pain out of 10), dated 6/21/25.Resident 73 received doses, as documented on his July 2025 and August 2025 MARs, despite having a pain level of 0 (no pain) on the following dates:7/27/25 at 8:03 p.m.8/7/25 at 7:39 p.m.8/8/25 at 8:47 p.m.8/25/25 at 10:00 p.m.8/26/25 at 6:03 p.m.During a telephone interview with the Consultant Pharmacist (CP) on 8/28/25 at 11:14 a.m., the CP stated, there is no reason to give [oxycodone], if there is no pain. The CP stated it is not appropriate to give the pain medication when the resident reports a pain level of 0.During an interview with the DON on 8/28/25 at 1:15 p.m., the DON confirmed oxycodone was given when the pain level was 0 on 5 occasions. The DON stated the nurse might have made documentation. I don't see it. The DON stated the pain medications should be given per the order because we don't want to overmedicate. The DON stated overmedicating could cause adverse (negative) effects from the medication itself.A drug review of oxycodone on Daily Med (https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=094b64b3-cd32-4de5-afb6-ea00d9caad74, accessed 8/29/25), a drug resource site, updated 4/24/24, indicated side effects, such as dizziness, nausea, vomiting, constipation, headache and sedation. Signs and symptoms of overdose listed included respiratory depression, somnolence, cold and clammy skin, low blood pressure, low blood sugar and coma.A review of the facility's policy and procedure (P&P) titled, Medication Administration and Storage, revised 3/2025, indicated, .accurately prepare, administer and document medications as per physician's order. |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure dignity and respect was provided for one of three sampled residents (73) during lunchtime, when a staff was standing over, while assisting and feeding the resident. This failure had the potential to affect the resident's self-esteem and resident's safety.Findings: Resident 73 was readmitted to the facility on [DATE], with diagnoses which included paraplegia (loss of movement and/or sensation, to some degree, of the legs), and blindness per the facility's admission Record. On 8/25/25 at 12:27 P.M., a lunch observation was conducted in Resident 73's room. Resident 73 was in bed with the lunch tray at the bedside table. A Certified Nursing Assistant (CNA) 1 was assisting and feeding Resident 73 while standing. There was a folded metal chair by the wall. CNA 1 was noted not to be in level with Resident 73. On 8/25/25 at 12:33 P.M., an interview was conducted with CNA 1. CNA 1 stated Resident 73 was confused and blind. CNA 1 stated Resident 73 was dependent on staff for all activities of daily living (ADLs, like eating). CNA 1 stated Resident 73 was not all the way up to CNA 1 while assisting and feeding Resident 73. CNA 1 stated he should have sat down to be at Resident 73's level for dignity and safety of Resident 73. ON 8/27/25 at 9:50 A.M., an interview was conducted with CNA 3. CNA 3 stated Resident 73 was blind and dependent on the staff on all ADLs. CNA 3 stated staff needed to sit down close to Resident 73 and explained to Resident 73 on what he wanted to eat first since the resident could not see. CNA 3 stated in that way, it was easy for the staff to see Resident 73 while eating for Resident 73's safety. On 8/28/25 at 8:53 A.M., an interview was conducted with the Director of Nursing (DON) 1 with the presence of DON 2. DON 1 stated Resident 73 was alert with occasional confusion. DON 1 stated the expectation was for the staff to sit with the residents, take their time while assisting and feeding the residents for dignity and safety of the resident. A review of the facility's policy titled, Dining Services and Meal Serving, revised 3/2025, indicated, .Procedures.8. Allow the resident plenty of time to eat. Sit next to any residents requiring physical assistance with feeding. |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop a baseline care plan (detailed plan with information about a patient's treatment, goal, and interventions) within 48 hours for three of 16 residents reviewed for baseline care plan related to:1. Resident 10's urinary catheter use.2. Resident 72's pain management.3. Resident 81's oxygen use. This deficient practice placed newly admitted residents with urinary catheters at risk for developing an infection, residents with pain to have unmanaged pain and residents with oxygen to be at risk for low or high oxygen level. Cross Reference to F 697 and F 695.Findings:<br><br>1.Resident 10 was admitted to the facility on [DATE], per the facility's admission Record.<br><br>On 8/25/25, a review of Resident 10's history and physical (H&P) was conducted. Resident 10's H&P dated 7/5/25, indicated Resident 10 was alert and oriented.<br><br>On 8/25/25, a review of Resident 10's minimum data set (MDS – a federally mandated resident assessment tool) dated 7/24/25, indicated Resident 10's brief interview for mental status (BIMS, ability to recall) score was 14/15, which meant Resident 10's cognition was intact. Resident 10 s bladder section of the MDS indicated Resident 10 had urinary catheter.<br><br>On 8/25/25 at 10:43 A.M., an observation of Resident 10 was conducted in his room. Resident 10 laid in bed with a urinary catheter attached to the bed rails. An attempt to interview Resident 10 was conducted. Resident 10 mumbled words which were incomprehensible.<br><br>On 8/26/25, a review of Resident 10's treatment administration record (TAR) for catheter care was conducted. Resident 10's catheter care had incomplete documentation.<br><br>On 8/27/25 at 9:14 A.M., an interview was conducted with Certified Nursing Assistant (CNA) 2. CNA 2 stated Resident 10 had a urinary catheter. CNA 2 stated catheter care was done by the CNAs.<br><br>On 8/27/25 at 9:47 A.M., an interview was conducted with CNA 3. CNA 3 stated catheter care was done by the CNAs and documented in the facility's computer system.<br><br>On 8/27/25 at 3:53 P.M., a joint review of Resident 10's clinical record and an interview was conducted with Licensed Nurse (LN) 1. LN 1 stated Resident 10 had a urinary catheter upon admission. LN 1 stated the treatment nurse was responsible for catheter care for residents with urinary catheter. LN 1 stated there was no initial care plan developed for Resident 10 related to his urinary catheter. LN 1 stated it was important to develop a care plan because it provided guidelines on how to take care of the residents.<br><br>On 8/28/25 at 9:06 A.M., a joint review of Resident 10's clinical record and an interview was conducted with the Director of Nursing (DON) 1 with the presence of DON 2. DON 1 stated she did not see a baseline care plan for Resident 10's urinary catheter. DON 1 stated it was important to develop a baseline care plan for the residents to address the residents' care needs and to manage their care.<br><br>A review of the facility's policy titled, Comprehensive Resident Centered Care Plan, revised 5/2025 indicated, .it is the policy of this facility that the interdisciplinary team (IDT) shall develop a<br>(continued on next page) |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | comprehensive care plan for each resident.A comprehensive care plan is developed within 14 days of resident admission.<br><br>2. Resident 72 was admitted to the facility on [DATE], with diagnoses which included pressure ulcer of right buttock (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence), per the facility 's admission Record.<br><br>Resident 72's H&P, dated 6/26/25, indicated Resident 72 had the capacity to make decisions.<br><br>On 8/25/25, a review of Resident 72's minimum data set (MDS – a federally mandated resident assessment tool) dated 7/2/25, indicated Resident 72's brief interview for mental status (BIMS, ability to recall) score was 15/15, which meant Resident 72's cognition was intact.<br><br>On 8/25/25 at 10:04 A.M., an observation and an interview of Resident 72 was conducted in her room. Resident 72 sat up in a wheelchair watching a television show. Resident 72 stated she had problem getting her pain medications over the weekend. Resident 72 stated she experienced pain all over her body and was not able to perform her favorite activity which was crocheting. Resident 72 stated she informed the assigned Licensed Nurse (LN) but did not get the pain medication. Resident 72 stated she was also informed she could not get an over-the-counter pain medication because there was no physician's order. Resident 72 stated her sister brought her over the counter pain meds on Sunday (8/24/25) to help with her pain.<br><br>On 8/27/25 at 9:34 A.M., an interview was conducted with Certified Nursing Assistant (CNA) 3. CNA 3 stated Resident 72 was alert and oriented. CNA 3 stated Resident 72 would ask for pain medication on her due time.<br><br>On 8/27/25 at 3:19 P.M., a joint review of Resident 72's clinical record and an interview was conducted with LN 1. LN 1 stated Resident 72 could make her needs known. LN 1 stated Resident 72 was admitted to the facility due to pressure ulcer on her right foot. LN 1 stated Resident 72 usually received her pain medication every day. LN 1 stated Resident 72 missed her pain medication dose over the weekend. LN 1 stated the last time Resident 72 received her pain medication was last Friday (8/22/25). LN 1 stated, When we run out of meds and the pharmacy takes a while to deliver them, we use the emergency meds from the emergency kit. LN 1 stated she did not see a care plan was developed for Resident 72's pain management. LN 1 stated it was important to manage Resident 72's pain and check her response to the medications and required another intervention.<br><br>On 8/28/25 at 9:06 A.M., a joint review of Resident 72's clinical record and an interview was conducted with the Director of Nursing (DON) 1 with the presence of DON 2. DON 1 stated she did not see a baseline care plan for Resident 72's pain management. DON 1 stated it was important to develop a baseline care plan for the residents to address the residents' care needs and to manage their care.<br><br>A review of the facility's policy titled, Comprehensive Resident Centered Care Plan, revised 5/2025 indicated, .it is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive care plan for each resident.A comprehensive care plan is developed within 14 days of resident admission.<br><br>3. Per the facility's undated admission Record ,Resident 81 was admitted to the facility on [DATE] with diagnoses that included Acute Respiratory failure with Hypoxia (absence of enough oxygen) .<br>(continued on next page) |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 8/25/25 at 10:15 A.M., an observation during the initial tour was conducted. Resident 81 had the oxygen nasal cannula (a device that gives extra oxygen) into her nostrils flowing at 3 liters per minute.<br><br>On 8/25/25 at 10:20 A.M., an interview with Resident 81 was conducted. Resident 81 stated she used the oxygen almost twenty-four hours due to Resident 81 could not breathe without the oxygen.<br><br>A review of the Minimum Data Set (MDS- a federally mandated assessment tool) dated 8/15/25 indicated a brief interview for mental status (BIMS) score of 05 which indicated Resident 81's cognition was severely impaired.<br><br>A review of Resident 81's baseline care plan on Oxygen use was not found in Resident 81's medical record.<br><br>On 8/25/25 at 11:00 A.M., an interview and record review with Licensed Nurse (LN) 1 was conducted. LN 1 stated there was no care plan regarding the use of oxygen on Resident 81's medical record.<br><br>On 8/28/25 at 11:20 A.M., an interview with the Director of Nursing (DON) was conducted. The DON stated the care plan is important as it outlines the specific healthcare and support needs of Resident 81's care. The DON stated it also acts as a communication to the healthcare staff regarding Resident 81's specific care needs.<br><br>A review of the facility's policy titled , Comprehensive Resident Centered Care Plan dated 5/2025 indicated, it is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive care plan for each resident. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure comprehensive resident-centered care plans were revised and implemented for two of 16 sampled residents (Resident 20 and 40) when: 1. Resident 20 had an altercation with his roommate and the care plan was not revised.2. Resident 40's activities care plan was not implemented. These failures had the potential to affect resident's care needs. Cross Reference F 679.Findings: 1. Resident 20 was admitted to the facility on [DATE], per the facility's admission Record. On 8/27/25, a review of Resident 20's clinical record was conducted. Resident 20's progress notes dated 8/21/25 indicated Resident 20 had physical contact with his roommate. The care plan noted in Resident 20's clinical record related to resident's physical contact with his roommate was not revised. On 8/27/25 at 8:40 A.M., an interview was conducted with Certified Nursing Assistant (CNA) 2. CNA 2 stated Resident 20 was alert and oriented. CNA 2 stated the report was Resident 20 had physical contact with his roommate. CNA 2 stated Resident 20 was taken to the acute care hospital after the incident. On 8/27/25 at 11:20 A.M., a joint review of Resident 20's clinical record and an interview was conducted with Licensed Nurse (LN) 2. LN 2 stated Resident 20 was transferred to acute care hospital. LN 2 stated Resident 20's care plan was not revised related to the altercation with his roommate. LN 2 stated the care plan should have been revised. On 8/27/25 at 11:28 A.M., a joint review of Resident 20's clinical record and an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated Resident 20's care plan was not revised. On 8/28/25 at 8:04 A.M., a joint review of Resident 20's clinical record and an interview was conducted with the Director of Nursing (DON) 1 with the presence of DON 2. DON 1 stated Resident 20 was alert, confused and would get easily agitated. DON 1 stated Resident 20 became agitated when his needs were not met timely. DON 1 stated Resident 20 had an altercation with another resident prior to the incident with his roommate. DON 1 stated per the LNs report, Resident 20 took the leg of the wheelchair and barricaded himself in his room. DON 1 stated Resident 20's roommate did not know what happened. Per DON 1, Resident 20 was agitated and shut the door until the police officers came to take Resident 20 to the acute care hospital. DON 1 stated the care plan for Resident 20's aggressive behavior was not revised and was not addressed. DON 1 stated the purpose of revising the care plan was to ensure Resident 20's aggressive behavior was addressed. A review of the facility's policy titled, Comprehensive Resident Centered Care Plan, Revised 5/2025, indicated, .4. Care plan will be revised as needed. 2. Resident 40 was admitted to the facility on [DATE], with diagnoses which included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness or the inability to move on one side of the body, making it hard to perform everyday activities like transferring), per the facility's admission Record. On 8/25/25, a review of Resident 40's history and physical (H&P), dated 7/4/25, indicated Resident 40 had the capacity to make decisions. On 8/25/25, a review of Resident 40's minimum data set (MDS - a federally mandated resident assessment tool) dated 7/9/25, indicated Resident 40's brief interview for mental status (BIMS, ability to recall) score was 15/15, which meant Resident 40's cognition was intact. The MDS also indicated Resident 40's functional abilities indicated he had upper and lower extremities impairment and that he required assistance from the staff on his activities of daily living (ADLs, like transferring). On 8/25/25 at 10:56 A.M., an observation and an interview was conducted with Resident 40 in his room. Resident 40 laid in bed watching a television show. Resident 40 stated he had been in the facility for almost two months. Resident 40 stated he was always in his bed and was bored. Resident 40 stated he needed help getting up and out of bed. Resident 40 stated he wanted to attend the activity but, They don't take me out. I wanted to attend. On 8/26/25, a review of Resident 40's care plan related to leisure activity was conducted. Resident 40's care plan indicated, Interventions.Invite to scheduled activities.Needs<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056182 | A. Building<br>B. Wing | 08/28/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Golden Hill Post Acute | 1201 34th St.<br>San Diego, CA 92102 |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | assistance activity functions. On 8/26/25 at 9:55 A.M., a follow up observation and an interview was conducted with Resident 40 in his room. Resident 40 stated, I just lay here, and they (staff) don't get me up. They don't offer me to attend the activity. Resident 40 stated he received the activity sheet, but staff did not offer him to get up and attend the activity. Resident 40 stated, How can I go there if they don't get me up? On 8/27/25 at 9:19 A.M., an interview was conducted with Certified Nursing Assistant (CNA) 2. CNA 2 stated Resident 40 was very alert and could make his needs known. CNA 2 stated Resident 40 wanted to get up, but he did not have his own wheelchair. On 8/27/25 at 9:39 A.M., an interview was conducted with CNA 3. CNA 3 stated Resident 40 was very alert and oriented. CNA 3 stated Resident 40 required a mechanical lift when transferring from the bed to the wheelchair. CNA 3 stated Resident 40 did not have his own wheelchair. CNA 3 stated she did not remember if she offered Resident 40 to get up and out of bed. CNA 3 stated she should have offered Resident 40 to attend activities to prevent boredom, bedsore and depression. On 8/27/25 at 3:00 P.M., a joint review of Resident 40's clinical record and an interview was conducted with Licensed Nurse (LN) 1. LN 1 stated Resident 40 was admitted to the facility on [DATE] for treatment of his lower extremity wound. LN 1 stated she was not aware Resident 40 wanted to attend the facility's activity program. LN 1 stated the staff should have offered Resident 40 the activity program so he was not confined to his room, did not feel boredom and to brighten his moods. LN 1 stated Resident 40's care plan on leisure activity was not implemented. On 8/28/25 at 8:41 A.M., a joint review of Resident 40's clinical record and an interview was conducted with the Director of Nursing (DON) 1 with the presence of DON 2. DON 1 stated Resident 40 required assistance from the staff when getting up and out of bed. DON 1 stated Resident 40's care plan was not implemented related to his leisure activity. DON 1 stated the staff should have offered Resident 40 to attend the activities for him to enjoy his stay at the facility. A review of the facility's policy titled, Comprehensive Resident Centered Care Plan, revised 5/2025 indicated, it is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive care plan for each resident. The policy did not indicate implementation of the care plan. |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide medication therapy in accordance with professional standards of practice for one of five sampled residents (Resident 58) when Licensed Nurse (LN) 11 did not flush (push water through) Resident 58's gastrostomy tube (G-tube, a device used to administer food and medications to individuals with difficulty swallowing) before and in between medication administration.This failure had the potential for Resident 58 not to get the full therapeutic benefit of her medications or to experience complications from her medications clogging in her G-tube.A review of Resident 58's clinical records indicated she was admitted to the facility on [DATE], with diagnoses that included, encounter for attention to gastrostomy.During the medication administration observation on 8/25/25 at 8:45 a.m., LN 11 was observed preparing and administering a total of 10 medications for Resident 58. LN 11 stated Resident 58 received two medications through her G-tube and the rest were administered by mouth.LN 11 prepared the following two medications for G-tube administration: Prevacid (for gastroesophageal reflux disease [GERD], acid reflux) SoluTab (breaks apart) tablet Dispersible (spreads out) 30 milligrams (mg, unit of measure), dated 7/17/25, and Multivitamin with minerals oral tablet for supplement, dated 7/17/25.LN 11 administered each medication separately. Flushing was not observed before medication administration or in between the two medications. After administering the two medications, LN 11 stated, Now I'll do a flush with 60 milliliters (mL, unit of measure) of water.During an interview with LN 11 on 8/26/25 at 8:44 a.m., LN 11 confirmed he did not flush before or in between G-tube medication administration during the medication observation. He stated there should be a flush before every medication, after every medication and in between.During an interview with the Director of Nursing (DON) on 8/27/25 at 8:06 a.m., the DON confirmed that there should have been a flush before medication administration. The DON stated Resident 58 had an active order for a 50 mL flush before and after G-tube medication administration. The DON stated, we would need to flush.because we don't want the tube to clog and we want to make sure the med is administered.A review of Resident 58's clinical record indicated Resident 58 had an active order since 7/20/25 for Flush GT[ube] with 50 mL of H2O [water] before and after med administration.A review of the National Library of Medicine's Medline Plus health information resource (Gastrostomy feeding tube - bolus: MedlinePlus Medical Encyclopedia, accessed 8/29/25), revised 10/20/24, indicated, Always flush the tube with.water between medicines. This will make sure that all the medicine goes in the stomach and is not left in the feeding tube.A review of the facility's policy and procedure (P&P) titled, Medication Administration and Storage revised 3/2025, indicated, .accurately prepare, administer and document medications as per physician's order.Preparing Enteral Medications.4. Flush tube with water before and after.as order.8. Flush tube with water in between each medication as order. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide routine nail care to one of three residents (Resident 48), reviewed for Activities of Daily Living (ADL, activities related to personal care) for dependent residents. As a result, Resident 48 was at risk for skin injury and infection.Findings: 1.Resident 48 was admitted to the facility on [DATE], with diagnoses which included stroke, per the facility's admission Record. Resident 48's history and physical (H&P), dated 7/17/25, indicated Resident 48 had altered mental status. On 8/25/25, a review of Resident 48's minimum data set (MDS - a federally mandated resident assessment tool) dated 7/22/25, indicated Resident 48's brief interview for mental status (BIMS, ability to recall) score was 12/15, which meant Resident 48's cognition was moderately impaired. The MDS also indicated Resident 48's functional abilities indicated he had upper extremity impairment and that he required assistance from the staff on his activities of daily living (ADLs). On 8/25/25 at 8:26 A.M., an observation and an interview were conducted of Resident 48 as he laid in bed. Resident 48's right hand was exposed, and fingernails appeared long. Resident 48 stated he wanted to cut his fingernails because they were long. Resident 48 stated he asked the staff about it but, They kept telling me it needs special person to cut it. With his left-hand fingernails, Resident 48 lifted his left arm. Resident 48 stated he could cut his left-hand fingernails but needed help with his right-hand fingernails since his left arm was weak. On 8/27/25 at 8:34 A.M, a joint observation of Resident 48 in his room and an interview was conducted with Certified Nursing Assistant (CNA) 2. CNA 2 stated Resident 48 was alert and oriented. CNA 2 stated Resident 48's right-hand fingernails were long and sharp, and needed to be trimmed. CNA 2 stated Resident 48 could potentially cut and hurt himself with those long fingernails. CNA 2 stated it was important to keep the fingernails cleaned and trimmed for hygiene and infection control practices. On 8/27/25 at 11:18 A.M., a joint observation of Resident 48 in his room and an interview was conducted with Licensed Nurse (LN) 2. LN 2 stated Resident 48 was alert and oriented but confusion. LN 2 stated Resident 48 had medium sized long fingernails. LN 2 stated Resident 48's fingernails should have been trimmed short to prevent him from injuring himself and getting an infection since bacteria could get into his skin when he scratched himself. LN 2 stated Resident 48 was not diabetic, and the CNAs could trim Resident 48's fingernails. On 8/28/25 at 8:28 A.M., a joint review of Resident 48's clinical record and an interview was conducted with the Director of Nursing (DON) 1 with the presence of DON 2. DON 1 stated Resident 48 had episodes of confusion. DON 1 stated Resident 48 had left arm weakness. DON 1 stated the expectation was for the staff to provide nail care to the residents because it was important for the residents' hygiene and infection control. A review of the facility's policy titled, Quality of Life, revised 6/2025 indicated, .It is the policy of this facility that residents are given the appropriate treatment and services to maintain or improve his/ her abilities.2. Residents who are unable to carry out activities of daily living (ADLs) will receive dignity and necessary services to maintain.Grooming.personal hygiene. |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide activities to meet all resident's needs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide individualized therapeutic and/or social activities according to their plan of care for one of one reviewed resident (Resident 40) that promotes their highest physical, mental, and psychosocial well-being. This deficient practice placed Resident 40 at risk for decreased emotional well-being, social isolation, and reduced quality of life due to the lack of meaningful engagement. Cross Reference F 656.Findings: Resident 40 was admitted to the facility on [DATE], with diagnoses which included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness or the inability to move on one side of the body, making it hard to perform everyday activities like transferring), per the facility's admission Record. On 8/25/25, a review of Resident 40's history and physical (H&P), dated 7/4/25, indicated Resident 40 had the capacity to make decisions. On 8/25/25, a review of Resident 40's minimum data set (MDS - a federally mandated resident assessment tool) dated 7/9/25, indicated Resident 40's brief interview for mental status (BIMS, ability to recall) score was 15/15, which meant Resident 40's cognition was intact. The MDS also indicated Resident 40's functional abilities indicated he had upper and lower extremities impairment and that he required assistance from the staff on his activities of daily living (ADLs, like transferring). On 8/25/25 at 10:56 A.M., an observation and an interview was conducted with Resident 40 in his room. Resident 40 laid in bed watching a television show. Resident 40 stated he had been in the facility for more almost two months. Resident 40 stated he was always in his bed and was bored. Resident 40 stated he needed help getting up and out of bed. Resident 40 stated he wanted to attend the activity but, They don't take me out. I wanted to attend. On 8/26/25 at 9:55 A.M., a follow up observation and an interview was conducted with Resident 40 in his room. Resident 40 stated, I just lay here, and they (staff) don't get me up. They don't offer me to attend the activity. Resident 40 stated he received the activity sheet, but staff did not offer him to get up and attend the activity. Resident 40 stated, How can I go there if they don't get me up? On 8/27/25 at 9:19 A.M., an interview was conducted with Certified Nursing Assistant (CNA) 2. CNA 2 stated Resident 40 was very alert and could make his needs known. CNA 2 stated Resident 40 wanted to get up, but he did not have his own wheelchair. On 8/27/25 at 9:39 A.M., an interview was conducted with CNA 3. CNA 3 stated Resident 40 was very alert and oriented. CNA 3 stated Resident 40 required a mechanical lift when transferring from the bed to the wheelchair. CNA 3 stated Resident 40 did not have his own wheelchair. CNA 3 stated she did not remember if she offered Resident 40 to get up and out of bed. CNA 3 stated she should have offered Resident 40 to attend activities to prevent boredom, bedsore and depression. On 8/27/25 at 3:00 P.M., a joint review of Resident 40's clinical record and an interview was conducted with Licensed Nurse (LN) 1. LN 1 stated Resident 3 was admitted to the facility on [DATE] for treatment of his lower extremity wound. LN 1 stated she was not aware Resident 40 wanted to attend the facility's activity program. LN 1 stated the staff should have offered Resident 40 the activity program, so he was not confined to his room, did not feel boredom and to brighten his moods. On 8/28/25 at 8:41 A.M., a joint review of Resident 40's clinical record and an interview was conducted with the Director of Nursing (DON) 1 with the presence of DON 2. DON 1 stated Resident 40 required assistance from the staff when getting up and out of bed. DON 1 stated the expectation was for the staff to offer Resident 40 to attend leisure activities for him to enjoy his stay at the facility and to promote emotional well-being. A review of the facility's policy titled, Quality of Life, revised 6/2025 indicated, .It is the policy of this facility that residents are given the appropriate treatment and services to maintain or improve his/her abilities. |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a tube feeding formula was labeled for one of one resident (58) reviewed for Parenteral Nutrition. This failure had the potential to affect Resident 58's health conditions and decline.Findings: A review of Resident 58's admission Record indicated that Resident 58 was admitted to the facility on [DATE] with diagnoses that included malignant neoplasm (cancerous tumors) of the tongue. Resident 58's history and physical (H&P), dated 7/17/25, indicated Resident 58 was alert and oriented to person, place and time. On 8/25/25, a review of Resident 58's minimum data set (MDS - a federally mandated resident assessment tool) dated 7/21/25, indicated Resident 58's brief interview for mental status (BIMS, ability to recall) score was 8/15, which meant Resident 58's cognition was moderately impaired. The MDS also indicated Resident 58's nutritional status indicated she was on feeding tube (a tube inserted through the stomach) upon admission. On 8/26/25 at 8:23 A.M., an observation and an interview of Resident 58 was conducted in her room. Resident 58 had a gastrostomy feeding tube with a formula in the pump machine. Resident 58's feeding tube formula was not labeled. Resident 58 stated she had cancer of the tongue and was placed on tube feeding. Resident 58 stated she did not know when the tube feeding was administered. On 8/26/25 at 8:40 A.M., a joint observation of Resident 58's tube feeding and an interview was conducted with the MDS Nurse (MDSN). The MDSN stated the tube feeding was not labeled and dated. The MDSN stated the Licensed Nurse (LN) who administered the tube feeding should have labeled and dated the tube feeding so the next nurse knew when it was administered. The MDSN stated the LN should also label/ date the water flush. On 8/27/25 at 3:48 P.M., a joint review of Resident 58's clinical record and an interview was conducted with LN 1. LN 1 stated the process when administering tube feeding to the resident was to label the tube feeding and water flush to ensure it wat the right resident, the right amount and when the tube feeding was administered. On 8/28/25 at 8:38 A.M., a joint review of Resident 58's clinical record and an interview was conducted with the Director of Nursing (DON) 1 with the presence of DON 2. DON 1 stated expectation was for the LNs to label the tube feeding and water flush with the resident's name, the flow rate, the time and the date the tube feeding was administered to ensure the resident was receiving the appropriate amount of hydration and nutrition and prevent further weight loss. A review of the facility's policy titled, Medication Administration, revised 3/2025, indicated, It is the policy of this facility to accurately prepare, administer and document medications as per physician's order.Preparing Enteral Medications.4.b. Ensure all feeding tubes and water flushes are labeled/date. |

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| F 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide for the safe, appropriate administration of IV fluids for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide care and treatment consistently for a Midline catheter (a thin, flexible tube inserted into a vein in the upper arm) for one of one resident (Resident 23) reviewed for Intravenous therapy. This failure had the potential to cause infection and affect Resident 23's health. Findings:Per the facility's admission Record , Resident 23 was admitted to the facility on [DATE] with diagnoses which included chronic kidney disease. (kidneys can no longer fully clean toxins from the blood) . On 8/25/25 at 9:17 A.M., a joint observation and interview with Resident 23 was conducted. Resident 23 had a midline catheter on her right arm with an unclear dated transparent dressing. Resident 23 stated she stated the midline catheter has not been flushed for a few days and that no one has changed the dressing since it was last done. Resident 23 stated she had been asking the licensed nurses if she still needed the midline catheter since Resident 23 knew she was done with her antibiotic treatment for her urinary tract infection (UTI) but no one has done anything about it. A review of Resident 23's Minimum Data Set ( MDS- a federally mandated assessment tool ) dated 7/1/25 indicated Resident 23 had a brief interview for mental status (BIMS) score of 15 which indicated Resident 23's cognition (thought process) was intact. On 8/27/25 at 10:34 A.M., an interview with the Assistant Director of Nursing (ADON) was conducted. The ADON stated the licensed nurses were to monitor the midline catheter site for signs and symptoms of infection every shift to prevent the occurrence of infection that could affect Resident 23's health. On 8/27/25 at 10:46 A.M., an interview and record review with Licensed Nurse (LN) 23 was conducted. LN 23 stated he would flush Resident 23's midline catheter before and after her antibiotic treatment. LN 23 does not remember the exact date he changed Resident 23's dressing on her right arm. LN 23 stated it was important for Resident 23's midline catheter to be flushed to avoid coagulation and to prevent it from being clogged. LN 23 stated Resident 23's midline catheter dressing should be changed as ordered by the Physician or per facility policy. A record review of Resident 23's order summary report ,dated 8/3/25 indicated the following: Midline flush orders: flush midline with 10 ml NS before and after IV medications and IV fluids. Maintenance : flush non used ports with 10 ml NS .Use only 10 ml syringes to flush all lumens. Monitor midline for s/s of infection /infiltration every shift. Notify Provider if present every shift. Midline care: Change all midline transparent dressings per sterile technique every 7 days and PRN wet, loose, or soiled. Change injection cap to lumen every 7 days and every PRN dressing change. A record review of Resident 23's Medication Administration Record ( MAR) indicated missed licensed nurse's signatures on the following dates and shifts: 8/19/25 and 8/20/25- flushing was blank 8/14/25 and 8/15/24- monitoring was blank on the AM and NOC shifts 8/17/25- monitoring was blank on the NOC shift 8/19/25 and 8/20/25 - monitoring was blank on the PM shift 8/21/25 and 8/22/25-monitoring was blank on AM shift 8/8/25- PRN or as needed dressing changed was documented. A record review of Resident 23's Medication Administration Record dated 8/25, indicated the dressing on the Midline catheter was changed on 8/8/25 as needed. There was no other record of the midline catheter dressing being changed or the catheter measured. On 8/28/25 at 9:21 A.M., an interview and record review with the Director of Nursing (DON) was conducted. The DON stated the dressing changes of the midline catheter needed to have the measurement of the catheter to prevent migration of the catheter and ensure placement and prevent possible complications for Resident 23's health. The DON stated the orders for measurement of the midline catheter was not in Resident 23's order summary report. The DON stated, the flushing of the midline catheter was not consistent same as the monitoring of the site.The DON stated, if it was not documented, it was not done. A review of the facility's dated 6/25 policy titled, Intravenous /Central/ Venous/ Maintenance did not provide clear guidance on the care of a Midline catheter . |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review , the facility failed to ensure an oxygen tubing was dated on 2 out of 2 residents (Resident 81,Resident 25) reviewed for Oxygen needs.This failure had the potential to affect Resident 81's and Resident 25's respiratory health.Findings:1) Per the facility's undated admission Record ,Resident 81 was admitted to the facility on [DATE] with diagnoses that included Acute Respiratory failure with Hypoxia (absence of enough oxygen) . On 8/25/25 at 10:15 A.M., an observation during the initial tour was conducted. Resident 81 had the oxygen nasal cannula (NC-a two-pronged plastic tubing used to deliver oxygen through the nose) regulated at 3 liters per minute via oxygen concentrator. Resident 81's oxygen tubing was not dated. On 8/25/25 at 10:20 A.M., an interview with Resident 81 was conducted. Resident 81 stated she used the oxygen almost twenty-four hours due to Resident 81 could not breathe without the oxygen. A review of the Minimum Data Set (MDS- a federally mandated assessment tool) dated 8/15/25 indicated a brief interview for mental status (BIMS) score of 05 which indicated Resident 81's cognition was severely impaired. A review of Resident 81's Order Summary Report indicated, change O2 tubing q week on Fridays every night shift on a Friday dated 8/5/25. On 8/25/25 at 10:45 A.M., an interview with Licensed Nurse (LN) 21 was conducted. LN 21 stated the oxygen tubing should have been dated to prevent spread of infection to Resident 81 and could cause possible side effects, if not dated to Resident 81's health. On 8/28/25 at 11:00 A.M., an interview with the Director of Nursing (DON) was conducted. The DON stated it was important to date the oxygen tubing to prevent infection and contamination that could affect Resident 81's condition, Resident 81 was dependent on the oxygen for her breathing. 2) Per the facility's undated admission Record, Resident 25 was admitted to the facility on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease(COPD -a chronic lung disease causing difficulty in breathing) . On 8/25/25 at 10:27 A.M., an observation during the initial tour was conducted. Resident 25 had the oxygen nasal cannula that goes into her nostrils ongoing at a flow rate of 3 liters per minute. Resident 25's oxygen tubing was not dated . A review of Resident 25's Order Summary Report indicated Resident 25 was on hospice care for a diagnosis of central nervous system lymphoma(a type of cancer that affects the lymph nodes). A review of resident 25's Minimum Data Set (MDS- a federally mandated assessment tool ) dated 8/10/25 indicated a brief interview for mental status (BIMS) score of 03 which indicated Resident 25's cognition (thought process) was severely impaired. A review of Resident 25's order summary report indicated, change o2 tubing q week on Fridays every night shift on a Friday dated 8/5/25. On 8/25/25 at 10:45 A.M., an interview with LN 21 was conducted. LN 21 stated the oxygen tubing should have been dated to prevent the spread of infection to Resident 25 which could affect Resident 25's health. On 8/28/25 at 11 A.M., an interview with the DON was conducted. The DON stated it was important to date the oxygen tubing to prevent infection and contamination that could affect Resident 25's condition, Resident 25 was dependent on the oxygen for her breathing. A review of the facility's policy on Oxygen Administration dated 5/2025 did not provide a clear guidance related to oxygen use. |

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| | 056182 | A. Building<br>B. Wing | 08/28/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Golden Hill Post Acute | 1201 34th St.<br>San Diego, CA 92102 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate pain management for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to assess and manage pain for one of two residents investigated for pain management (Resident 72). As a result, the deficient practice had the potential for unmanaged pain. Cross Reference F 655.Findings: Resident 72 was admitted to the facility on [DATE], with diagnoses which included pressure ulcer of right buttock (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence), per the facility 's admission Record. Resident 72's H&P, dated 6/26/25, indicated Resident 72 had the capacity to make decisions. On 8/25/25, a review of Resident 72's minimum data set (MDS - a federally mandated resident assessment tool) dated 7/2/25, indicated Resident 72's brief interview for mental status (BIMS, ability to recall) score was 15/15, which meant Resident 72's cognition was intact. On 8/25/25 at 10:04 A.M., an observation and an interview of Resident 72 was conducted in her room. Resident 72 sat up in a wheelchair watching a television show. Resident 72 stated she had problem getting her pain medications/meds over the weekend. Resident 72 stated she last received her pain meds on Friday (8/22/25). Resident 72 stated she experienced pain all over her body and was not able to perform her favorite activity which was crocheting. Resident 72 stated she informed the assigned Licensed Nurse (LN) but did not get the pain medication. Resident 72 stated she was also informed she could not get an over-the-counter pain medication because there was no physician's order. Resident 72 stated her sister brought her over the counter pain meds on Sunday (8/24/25) to help with her pain. On 8/27/25 at 9:34 A.M., an interview was conducted with Certified Nursing Assistant (CNA) 3. CNA 3 stated Resident 72 was alert and oriented. CNA 3 stated Resident 72 would ask for pain medication on her due time. On 8/27/25 at 3:19 P.M., a joint review of Resident 72's clinical record and an interview was conducted with LN 1. LN 1 stated Resident 72 could make her needs known. LN 1 stated Resident 72 was admitted to the facility due to pressure ulcer on her right foot. LN 1 stated Resident 72 usually received her pain medication every day. LN 1 stated Resident 72 missed her pain medication dose over the weekend (8/23/25 to 8/24/25). LN 1 stated the last time Resident 72 received her pain medication was last Friday (8/22/25). LN 1 stated, When we run out of meds and the pharmacy takes a while to deliver them, we use the emergency meds from the emergency kit. LN 1 stated Resident 72's pain medication was delivered to the facility on (Tuesday) 8/26/25. LN 1 stated it was important to manage Resident 72's pain to maintain her activities of daily living (ADLs). On 8/28/25 at 8:58 A.M., a joint review of Resident 72's clinical record and an interview was conducted with the Director of Nursing (DON) 1 with the presence of DON 2. DON 1 stated expectation was for the LNs to notify the physician if there was no over the counter pain medication for Resident 72 and to ensure pain medications were available for Resident 72 to manage he pain. A review of the facility's policy titled, Physician Orders, revised 5/2025, indicated, It is the policy of this facility that drugs shall be administered.It is the policy of this facility to.implement orders.upon the written order of a person duly licensed. |

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| Golden Hill Post Acute | 1201 34th St.<br>San Diego, CA 92102 |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident?s drug regimen must be free from unnecessary drugs.<br><br>Based on interview and record review, the facility failed to ensure one out of five residents (Resident 72) was free from unnecessary medications when blood pressure (BP) and heart rate (HR) hold parameters were not followed with the administration of medications.This failure had the potential for Resident 72 to experience low BP and low HR.A review of Resident 72's clinical record indicated she had an active order for atenolol 50 milligram (mg, unit of measure) tablet, give one and half tablet by mouth two times a day (at 9 a.m. and 5 p.m.) for hypertension (HTN, high blood pressure). Hold if HR less than 60, originally dated 6/28/25. Resident 72 received doses, as documented on her July 2025 and August 2025 Medication Administration Record (MAR), despite a HR less than 60 on the following dates:7/6/25 HR 53 the 9 a.m. dose was administered7/13/25 HR 57 the 9 a.m. dose was administered7/18/25 HR 57 the 9 a.m. dose was administered8/2/25 HR 57 the 5 p.m. dose was administered8/12/25 HR 55 the 5 p.m. dose was administered8/13/25 HR 56 the 5 p.m. dose was administeredA review of Resident 72's clinical record indicated she had an active order for lisinopril 5 mg tablet, give one tablet by mouth one time a day for hypertension. Hold for systolic blood pressure (SBP, the top number on the BP reading) less than 110 and HR 60, dated 6/26/25. Resident 72 received doses, as documented on her July 2025 and August 2025 MARs, despite having SBP less than 110 or HR less than 60 on the following dates:7/6/25 BP 106/54 and HR 537/13/25 BP 144/91 and HR 577/18/25 BP 135/75 and HR 578/2/25 BP 116/69 and HR 57During an interview with the Consultant Pharmacist (CP) on 8/28/25 at 11:14 a.m., the CP was asked about the lisinopril dose on 8/2/25. The CP stated that if either the SBP or HR fell below the threshold, the dose should be held.During an interview with the Director of Nursing (DON) on 8/28/25 at 1:15 p.m., the DON verified the instances when BP meds were given despite the hold parameters. When asked if lisinopril should be held only when both the SBP and HR are below the threshold, the DON stated No, either one. The DON stated that it is not appropriate to give BP meds despite the hold parameters because the dose is made to maintain their BP and HR at a certain level. HR might drop lower.A drug review of the medication, lisinopril, on Daily Med (DailyMed - LISINOPRIL- lisinopril tablet, accessed 8/29/25), a drug resource site, updated 11/3/21, listed hypotension (low BP) as the most likely manifestation of overdosage and as one of the side effects, in addition to dizziness and syncope (fainting).A drug review of the medication, atenolol, on Daily Med (DailyMed - ATENOLOL tablet, accessed 8/29/25), updated 2/21/24, indicated side effects such as low HR, postural hypotension (a drop in BP upon changing to an upright position), dizziness, tiredness and drowsiness.A review of the facility's policy and procedure (P&P) titled, Medication Administration and Storage, revised 3/2025, indicated, .accurately.administer.medications as per physician's order. |

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| Golden Hill Post Acute | 1201 34th St.<br>San Diego, CA 92102 |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility had a medication error rate of 10% when three medication errors occurred out of 30 opportunities during the medication administration observation for two out of five residents (Residents 5 and 58). This failure resulted in Residents 5 and 58 not receiving medications as ordered and had the potential for both residents not to get the full therapeutic benefit of their medications. This failure also had the potential for Resident 58 to experience complications from her medications clogging in her gastrostomy tube (G-tube, a device used to administer food and medications to individuals with difficulty swallowing). 1. During the medication administration observation on 8/25/25 at 8:45 a.m., Licensed Nurse (LN) 11 was observed preparing and administering a total of 10 medications for Resident 58. LN 11 stated Resident 58 received two medications through her G-tube and the rest were administered by mouth. LN 11 prepared the following two medications for G-tube administration: Prevacid (for gastroesophageal reflux disease [GERD], acid reflux) SoluTab (breaks apart) tablet Dispersible (spreads out) 30 milligrams (mg, unit of measure), dated 7/17/25 Multivitamin with minerals oral tablet for supplement, dated 7/17/25LN 11 administered each medication separately. Flushing (pushing water through the G-tube) was not observed before medication administration or in between the two medications. After administering the two medications, LN 11 stated, Now I'll do a flush with 60 milliliters (mL, unit of measure) of water.During an interview with LN 11 on 8/26/25 at 8:44 a.m., LN 11 confirmed he did not flush before or in between G-tube medication administration during the medication observation. He stated there should be a flush before every medication, after every medication and in between.During an interview with the Director of Nursing (DON) on 8/27/25 at 8:06 a.m., the DON confirmed that there should have been a flush before medication administration. The DON stated Resident 58 had an active order for a 50 mL flush before and after G-tube medication administration. The DON stated, we would need to flush.because we don't want the tube to clog and we want to make sure the med is administered.A review of Resident 58's clinical record indicated Resident 58 had an active order since 7/20/25 for Flush GT[ube] with 50 mL of H2O [water] before and after med administration.A review of the facility's policy and procedure (P&P) titled, Medication Administration and Storage revised 3/2025, indicated, .Preparing Enteral Medications.4. Flush tube with water before and after.as order.8. Flush tube with water in between each medication as order. 2. During the medication administration observation on 8/25/25 at 9:41 a.m., LN 2 was observed preparing and administering 11 medications for Resident 5. LN 2 stated she did not have Resident 5's twelfth medication, Vitamin D 5000 international units (IU, unit of measure), in stock. LN 2 stated she cannot give the Vitamin D pending pharmacy supply.We have different Vitamin Ds, but I can't give it to her because it's a different strength. LN 2 stated that the Vitamin D would not be coming in on 8/25/25, although nursing staff told her it was ordered last Thursday (on 8/21/25).A review of Resident 5's clinical record indicated Resident 5 had an active order since 7/22/25 for Vitamin D3 (a type of Vitamin D) oral tablet 125 micrograms (mcg, unit of measure). Vitamin D 125 mcg is equivalent to Vitamin D 5000 IU. Give 1 tablet by mouth one time a day for Vit[[NAME]] D deficiency [low Vitamin D levels]. The review also indicated Resident 5 had an active order since 7/10/25 for carvedilol tablet 6.25 mg Give 1 tablet by mouth two times a day for hypertension [high blood pressure]. Carvedilol administration was not observed during the medication observation. Documentation on Resident 5's MAR indicated carvedilol was administered.During an interview with LN 2 on 8/25/25 at 11:50 a.m., LN 2 stated, I didn't give [the carvedilol]. There were so many things.I'm crossing [the MAR] out and will give it now.During an interview with the DON on 8/27/25 at 8:59 a.m., the DON stated it is not acceptable for residents to be without their medications. The DON stated, They're taking their medications for a reason.A review of the facility's P&P titled, Medication Administration and Storage, revised 3/2025, indicated, .accurately prepare, administer and document medications as per physician's order.A review of the (continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | facility's P&P titled, Pharmacist, Services of a Licensed, revised 6/2025, indicated, The pharmacist is responsible for helping the facility obtain and maintain timely and appropriate pharmaceutical services that support residents' healthcare needs.1.including.accurate acquiring, receiving, dispensing, and administering of drugs.6. Strive to assure.medications are requested, received, and administered in a timely manner as ordered by the physician. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, interviews and record review, the facility failed to ensure safe and sanitary measures were met in the kitchen during dietary operations according to standards of practice when food items were free from contaminants. This finding had the potential to expose the facility's residents to unsafe and unsanitary food practices that could lead to widespread foodborne illnesses.Findings: On 8/25/25 at 8:08 A.M., an observation of the produce walk-in refrigerator and an interview was conducted with the Certified Dietary Manager (CDM). There were two packs of strawberries with white porous materials and a jar of Caesar salad dressings with sticky material around the edges of the jar. On 8/25/25 at 9:01 A.M., an interview was conducted with the CDM with the presence of the Registered Dietitian (RD). The CDM stated the strawberries will be discarded. The CDM stated the staff will not serve strawberries. The CDM stated the dietary staff should have rotated the produce. The CDM asked a dietary aide to clean the edges of the jar of the Caesar salad dressing. The CDM stated, They probably poured into a container. CDM stated the dietary staff should have kept the food containers cleaned because it could potentially contaminate the food and would not be good for food consumption. A review of the facility's undated policy, titled Procedure for Refrigerated Storage, .15. Produce will be delivered frequently and rotated.to assure fresh product us used.According to the guideline produce may be kept longer if there is no visible signs of spoilage. |