

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555136	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2025
NAME OF PROVIDER OR SUPPLIER Poway Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 15632 Pomerado Road Poway, CA 92064	

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. (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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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure prescribed medications (meds) were administered as ordered by the physician for two of two sampled residents (Resident 1, Resident 2) As a result, Resident 1 was found unresponsive and life sustaining measures were performed including cardiopulmonary resuscitation (CPR). A. Resident 1 was admitted to the facility on [DATE] at 1:37 P.M., with a diagnosis of atherosclerotic heart disease of native coronary artery and atrial fibrillation (irregular heartbeat that affects blood flow) per the facilities admission record and admission note. A review of Resident 1's physicians orders (PO), dated [DATE], Indicated Resident 1 was a full code The PO's indicated Resident 1 was prescribed the following meds to be administered on [DATE] at 9 P.M. Risperidone (mood disorder med) 2 mg (milligram), one tablet (tab) by mouth (PO) in the evening. Trazodone HCl (an antidepressant) 50 mg, one tab PO at bedtime. Budesonide-Formoterol Fumarate (inhaler for chronic obstructive pulmonary disorder, COPD) 80-4.5 MCG (microgram)/ACT (actuation), 2 puffs twice a day. Carvedilol (cardiac med for high blood pressure) 25 mg, one tablet PO two times a day. Dronedaron HCL (med that helps maintain normal heart rhythm) 400 mg, one tablet PO, two times a day. Eliquis (blood thinner for clot prevention) 5 mg, one tablet PO, two times a day. A review of Resident 1's nursing note, dated [DATE] at 4:35 A.M., indicated, .New Admit, monitoring resident alert able to make simple needs known appears somewhat confused at times. A review of Resident 1's progress note, dated [DATE] at 7:58 A.M., indicated, . resident found not breathing, non-responsive by CNA, code blue immediately initiated. During an interview on [DATE] at 1:43 P.M, licensed nurse (LN) 1 stated, the LN should notify the pharmacy a new admission's medication orders, and the pharmacy will deliver the medications. LN 1 stated, if a new admission's evening medications are not delivered by administration time, the LN should pull the scheduled medications from the e-kit pyxis (emergency medication storage machine) if they are available. LN 1 stated nurses are instructed to call the pharmacy if the medication is an important medication and not available for administration. LN 1 stated if the medication is important enough to be in the e-kit, it is important to remove and give at the ordered time of administration. During an observation, interview and record review on [DATE] at 2:15 P.M., the assistant director of nursing (ADON) and director of nursing (DON) reviewed med inventory of the facility's e-kit pyxis. The inventory indicated the e-kit pyxis contained three of Resident 1's six prescribed evening meds including: 10 tabs of Eliquis 2.5mg 10 tabs of Carvedilol 6.25mg 18 tabs of Trazodone 50mg The e-kit pyxis did not contain any doses of Risperidone, Budesonide-Formoterol, or Dronedaron. A review of Resident 1's eMAR (electronic medication administration record) dated [DATE] indicated Resident 1 did not receive the following scheduled medications at 9 PM as ordered: RisperidONE 2 mg PO TraZODone HCl 50 mg PO Budesonide-Formoterol Fumarate 80-4.5 MCG/ACT inhaler Carvedilol 25 mg PO Dronedaron HCl 400 mg PO Eliquis 5 mg PO A review of the e-kit transaction history dated, [DATE]-[DATE], indicated none of the three available medications in the e-kit were ever removed to be administered to Resident 1. A review of Resident 1's medication administration progress notes, dated [DATE], indicated , .New admit; meds not here yet. , as the reason all six medications, scheduled for 9:00 P.M., were not administered. During an interview on [DATE] at 3:55 P.M., LN 2 stated upon admission to the facility a resident's medication orders will be reconciled and approved and submitted to be filled and delivered by the pharmacy. LN 2 stated the nurse will access medications in the ekit pyxis if they have not been delivered to the facility by the time of medication pass. LN 2 stated the physician should be notified if the med has not been delivered and is not in the ekit by the time of scheduled administration. Once the nurse administers the medication it should be charted as given in the medication administration record (MAR). LN 2 stated a resident who has a diagnosis of heart disease or atrial fibrillation would be at risk for developing cardiac complications such as a blood clots, headache, or chest pain if they did not receive ordered cardiac medications. During an interview on [DATE] at 3:31 P.M., the Nurse Practitioner (NP), stated the licensed nurse is supposed to notify the NP or physician when a new admission arrives to the facility and obtain verbal authorization over the phone for the resident's medications. The NP stated the approved resident medication list should be sent or called into the pharmacy and the medications should be delivered by the pharmacy. The NP stated if a resident is admitted to the facility at 4 P.M. and does not receive their evening medications the NP or the physician should be notified. A review of Resident 1's progress notes did not indicate the NP or the physician were notified Resident 1 did not receive evening medications or that the medications had not been delivered from the pharmacy. During</p>