

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555144	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/10/2025
NAME OF PROVIDER OR SUPPLIER St. Pauls Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 235 Nutmeg Street San Diego, CA 92103	

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)
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to prevent multiple significant medication errors when oxycodone/apap (a narcotic pain medication mixed with acetaminophen, also known as Percocet) was administered to one sampled resident (Resident 1), nine times without a physician's order.</p> <p>As a result, Resident 1 was placed at risk for serious adverse drug effects including, oversedation, respiratory depression, or medication interaction, due to repeated administration of a controlled substance without physician oversight or a valid prescription.</p> <p>In addition, the controlled drug record (CDR) used to record the Percocet administration was handwritten and lacked essential labeling information contributing to repeated errors and broader concerns with medication labeling and storage practices. (See tag F761)</p> <p>Findings:</p> <p>Resident 1 was admitted to the facility on [DATE] with a diagnosis of malignant neoplasm (a cancerous tumor) of the bone and a pathological fracture (bone break due to disease) of the left humerus (large bone in upper arm) per the facility face sheet.</p> <p>During an interview on 5/22/25 at 9:15 A.M., the director of nursing (DON) stated Resident 1 was given the wrong medication by licensed nurse (LN) 2 on 5/8/25.</p> <p>During an interview on 5/22/25 at 9:30 A.M., with Resident 1 at the facility, Resident 1 stated he had been treated with oxycodone 5 milligrams (mg) every four hours as needed for pain related to his broken arm. Resident 1 stated he was on 10 mg of oxycodone at one point following surgery. Resident 1 stated he was not aware of any other controlled substances the facility was giving him for pain.</p> <p>A review of Resident 1's active physicians orders (PO), dated 5/10/25, indicated Resident 1 was prescribed oxycodone 5mg tablet for severe pain, 1 tablet, as needed, every eight hours starting 5/6/25.</p> <p>A review of Resident 1's clinical note, dated 5/10/25 at 3:15 A.M., indicated licensed nurse (LN) 3 had found a medication discrepancy during a narcotic count at 11:30 P.M. on 5/9/25. The clinical note indicated Percocet 10/325 milligrams (mg) was given on 5/8/25 instead of the ordered 5mg of oxycodone (narcotic without acetaminophen) ordered.</p> <p>(continued on next page)</p>

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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview at the facility on 5/22/25 at 9:26 A.M., with licensed nurse (LN) 1, LN 1 stated nurses at the facility were expected to follow the five rights of medication administration which included the right resident, right medication, right dose, right route and right time to prevent medication errors. LN 1 stated if the resident name, medication name, dose, route or time in the medication order does not match the medication label the medication should not be given.</p> <p>During an interview and record review at the facility on 5/22/25 at 11:55 A.M., with the minimum data set (MDS) coordinator, Resident 1's medication order history was reviewed. The MDS coordinator stated Resident 1 came to the facility on 3/12/25. with a prescription for Percocet from the hospital but that the order was discontinued by the facility nurse practitioner (NP) on admission. The MDS coordinator confirmed Resident 1 was not prescribed Percocet since it was discontinued on 3/12/25. The MDS coordinator stated Resident 1 brought bottle of Percocet to the facility on admission.</p> <p>During an interview and review of Resident 1's medical record with the DON on 5/22/25 at 11:59 A.M. , the DON stated it appeared Resident 1's CDR indicated multiple nurses gave Resident 1 Percocet that was stored in the medication cart but that had no corresponding order. The DON stated she was not sure what happened but LN 2 and the other nurses who signed the CDR should not have given the medication without an order or pharmacy approval.</p> <p>During a telephone interview with LN 3 on 6/10/25 at 2:10 P.M., LN 3 stated he identified LN 2's medication error during a controlled substance medication count. LN 3 stated on 5/9/25 at 11 P.M., he conducted a controlled substance count for his medication cart. LN 3 stated Resident 1 had brought a bottle of Percocet into the facility from an outside source, and it was being kept in the controlled drug storage drawer until his family came to pick it up. LN 3 stated all containers of controlled medications were counted if they were in the drawer even if they were discontinued and waiting for disposal. LN 3 stated the medication count for the bottle of Resident 1's Percocet was missing one pill. LN 3 stated he looked at the controlled drug records for Resident 1 and identified LN 2 had given one pill of Percocet to Resident 1 on 5/8/25 at 1700. LN 3 confirmed with LN 2 that she gave Percocet to Resident 1. LN 3 stated LN 2 said she did not know that Percocet was a different medication than oxycodone. LN 3 stated he confirmed during an interview with LN 2 that she did not check the medication against the PO before administering it to Resident 1. LN 3 stated he was aware the controlled drug record indicated other nurses had given the Percocet as well.</p> <p>A review of Resident 1's controlled drug record indicated Resident 1 was administered different doses of Percocet 10/325mg on 9 separate occasions by 5 different nurses. The doses of Percocet 10/325mg administered to Resident 1 were:</p> <p>3/18/25 at 2:00 PM 2 tablets</p> <p>3/18/25 at 8: 41PM 2 tablets</p> <p>3/19/25 at 3:10 AM 2 tablets</p> <p>3/19/25 at 7:43 AM 2 tablets</p> <p>3/19/25 at 12:22 AM 2 tablets</p> <p>3/19/25 at 4:30 PM 2 tablets</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3/19/25 at 8:34 PM 2 tablets</p> <p>3/20/25 at 1:00 AM 1 tablet</p> <p>5/8/25 at 5:00 PM 1 tablet given by LN 2</p> <p>A review of Resident 1's medication administration record (MAR) did not include an administration history or directions administer to for the Percocet 10/325mg.</p> <p>A review of Resident 1's clinical note, dated 3/12/25 at 7:44 P.M., indicated, . NP here to assess resident, new orders to 1) d/c Percocet PRN .</p> <p>A review of the facility policy, dated March 2025, titled, administering oral medications indicated .Purpose: the purpose of this procedure is to provide guidelines for the safe administration of oral medications.</p> <p>Preparation: 1. verify that there is a physician's medication order for this procedure . Steps in procedure . 6. Check the label on the medication and confirm the medication name and dose with the MAR . Check the medication dose . 9. Prepare the dose of medication . b. For narcotics. Check the narcotic record for the previous drug count and compare with the supply on hand .</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation interview and record review the facility failed to ensure that controlled substances were properly labeled and stored for one of two sampled Residents (1) during a medication cart audit when:</p> <ol style="list-style-type: none"> 1. The facility did not remove discontinued controlled medications from Resident 1's active stock in the north wing medication cart 2. The facility failed to secure and label a bottle of oxycodone/apap (a narcotic pain medication mixed with acetaminophen, also known as Percocet) brought into the facility by Resident 1 which allowed the narcotic to remain in the medication cart and be administered without a valid physician's order (PO, see F760). <p>As a result, resident 1 was given an unprescribed narcotic and was placed at increased risk for administration of additional discontinued unprescribed narcotics due to improper labeling and storage.</p> <p>Findings:</p> <p>Resident 1 was admitted to the facility on [DATE] with a diagnosis of malignant neoplasm (a cancerous tumor) of the bone and a pathological fracture (bone break due to disease) of the left humerus (large bone in upper arm) per the facility face sheet.</p> <p>During an interview on [DATE] at 9:30 A.M., with Resident 1 at the facility, Resident 1 stated he was being treated with narcotics for pain related to his bone fracture and cancer. Resident 1 stated he was being given oxycodone 5 milligrams (mg) every 4 hours as needed. Resident 1 stated he brought a bottle of previously prescribed narcotics into the facility and the facility took the bottle on admission. Resident 1 stated he had not seen the bottle since it was taken by staff.</p> <p>A review of Resident 1's active physicians orders (PO), dated [DATE], indicated Resident 1 was prescribed oxycodone 5mg tablet for severe pain, 1 tablet, as needed, every eight hours starting. No other active orders for controlled substances were found in Resident 1's PO.</p> <ol style="list-style-type: none"> 1. During an audit of the north wing medication cart and interview with licensed nurse (LN) 4 on [DATE] at 12:40 P.M., a blister pack of oxycodone 10mg immediate release tablets prescribed to resident one was found stored in the controlled substance drawer with the active medication stock. A review of resident 1's physicians orders (PO) indicated that the order for oxycodone 10mg had been stopped on [DATE]. LN 4 stated she almost made a medication error on [DATE] because she accidentally popped a 10mg milligram oxycodone tablet from the discontinued medication bubble pack instead of a 5 mg oxycodone tablet that was ordered. LN 4 stated she notified the charge nurse and wasted the 10mg tablet on [DATE] but was not sure why the medication was still available in the cart. LN 4 stated it should not be in the cart because nurses can make an administration errors and give the resident too much medication. <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. During an interview and record review with the minimum data set (MDS) coordinator at the facility, on [DATE] at 11:55 A.M., the MDS coordinator stated resident 1 was admitted on [DATE] with a prescription for Percocet from the hospital, but the order was discontinued upon admission by the nurse practitioner.</p> <p>A review of Resident 1's clinical note, dated [DATE] at 7:44 P.M., indicated, . NP here to assess resident, new orders to 1) d/c Percocet PRN .</p> <p>During an interview with LN 3 on [DATE] at 2:10 P.M., LN 3 stated he identified a medication error during a controlled substance medication count of medication cart NUMBER on [DATE] at 11 P.M. LN 3 stated Resident 1 was administered Percocet (a narcotic pain medication) from a medication bottle Resident 1 had brought into the facility from an outside source. LN 3 stated the Percocet was being kept in the controlled drug storage drawer until Resident 1's family could come to pick it up. LN 3 stated Resident 1 did not have a physician's order for Percocet.</p> <p>LN 3 stated that controlled drug record (CDR) sheets are typically provided by the pharmacy and include a printed label that matches the medication's pharmacy-issued packaging. LN stated the CDR sheet used for Resident 1's Percocet was handwritten and did not include a matching pharmacy label because it was not issued by the facilities pharmacy. LN 3 stated the label on a CDR should always match the pharmacy label on the medication packaging and the physician's order in the medical record. LN 3 stated if any information is missing or inconsistent the medication should not be administered. LN 3 stated all labels should include the resident's name, medication name, dosage, route and administration time. LN 3 stated if a resident received the wrong dose or the wrong medication it could put them at risk for overdosing and various other adverse reactions.</p> <p>A review of the CDR for Resident 1's Percocet 10/325mg bottle indicated the handwritten CDR label was missing the medication dose, time and route of administration.</p> <p>During an interview with the Director of Nursing (DON) on [DATE] at 2:47 P.M., the DON stated the Percocet brought into the facility from an outside source by Resident 1 should not have been stored with the active controlled medications in the medication cart. The DON stated the label on the CDR should not have been handwritten and should have contained the medication name, resident name, prescription number, dose, route and physician. The DON acknowledged the handwritten CDR did not reflect the facilities standard of labeling. The DON stated the label on the medication should match the label on the controlled drug record. The DON acknowledged that an expired bubble pack of 10 mg of oxycodone was stored on the medication cart with the active controlled substance medications for Resident 1 for over a month after it had been discontinued by the physician. The DON stated she recognized the facility had to work on their medication storage and labeling practices and that residents were at an increased risk of receiving the wrong dose or wrong medication without adequate labeling and storage practices.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility policy, dated [DATE], titled, medication labeling and storage, indicated, . policy statement: the facility stores all medications and biologicals and locked compartments under proper temperature humidity and light controls only authorized personnel have access to keys; policy interpretation and implementation; medication storage . 3. If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items . Medication labeling; 1. Labeling of medications and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices. 2. The medication label includes, at a minimum: A. medication name . b. prescribed dose; c. strength; d. expiration date, when applicable; e. resident's name; f. route of administration; and g. appropriate instructions and precautions .</p>		