STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555362	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casa DE Las Campanas	18655 W. Bernardo Drive San Diego, CA 92127

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Observation, Interview and Record Review, the facility failed to keep one of five sampled residents (Resident 1) safe from medication errors. This failure caused Resident 1 to receive the wrong medication and posed a risk to Resident 1's health and safety.Findings:Per the facility's admission Record, Resident 1 (Res 1) was admitted to the facility on [DATE]. Resident 1's admission diagnosis was Myasthenia Gravis (a chronic disorder that affects where nerves communicate with muscles). Per the Minimum Data Set (MDS - a resident assessment tool) assessment, Section K0520 indicates that Resident 1 had a G-Tube (a tube that goes into the stomach through the abdominal wall for nutrition, medication, and hydration) present on admission and while a resident in the facilityPer a record review of Res 1 electronic medical record (EMR) on 7/24/2025, the change of condition note dated 3/20/2025 at 4:15 P.M. LN2 documented that Resident was sitting by door disconnected from feeding tube. Nurse gave crushed meds with applesauce by mouth causing resident to choke. Three nurses alerted, suction used on mouth and oxygen given. 911 called.Resident 1's record was reviewed on 7/24/2025. During a review of Res 1's Order Summary Review, the record indicated a new order was placed for medication via G-Tube. The record further indicated that the medications were discontinued and reordered on 2/13/2025, 2/15/2025, and 3/6/2025. Thus, the record showed that there had been no recent changes to the medication orders and that the medications had been administered via the appropriate route (g-tube). LN1 did not give Res1's medications by the ordered route. (g-tube).During an observation and interview on 7/24/2025 at 9:15 A.M. Medication Nurse 1 (MED1) was observed passing medications. MED1 checked medications against the physician's orders, dispensed medications to plastic cups, verified patient, medication, dosage, route, and time. MED1 stated the policy for G-Tube medication administration: Check the Medication Administration Record (MAR); verify patient, medication, dose, route, and time; verify that medications can be crushed.During an interview with the Director of Nursing (DON) on 7/24/2025 at 10:05 A.M., the DON stated Resident 1 was a tube fed resident. On 3/19/2025, R1 was seated in a chair in the hall. The tube feeding had been turned off. Licensed Nurse 1 (LN1) saw R1 seated in the hall and offered her medications, R1 asked for them to be crushed. LN1 crushed the medications, mixed them in applesauce and gave them to R1 by mouth. R1 began to choke and coughed out the applesauce and medications. Staff took R1 into her room, suctioned her, and called 911.The DON stated, LN1 did not verify the name of the resident prior to giving medications. The DON continued She (LN1) broke many, many things related to our medication administration policies. Nurses are expected to follow the Five Rights when passing medications. The DON further stated that LN1 did not properly identify the resident, the medications, or the correct route. The DON further stated that all facility staff who pass medications are observed by the pharmacist to ensure safety at least every six months. Registry staff are observed based on how frequently they work.During a record review on 7/24/2025 at 9 A.M. The document titled PharMerica Medication Administration Observation Report indicated the most recent observation of LN1 was on 11/25/2024.On 7/30/2025 at 12:45 P.M., R1's attending physician (MD) was interviewed. R1's MD stated that R1 was tube fed, and she was not to have anything by mouth. The MD further stated that this incident had the potential for a very bad outcome, but I saw her the following day, and she was ok.During a review of the facility policy titled Administering Medications dated April 2019, indicated .9. The individual administering medications verifies the resident's identity before giving the medications. Methods of identifying the resident include a. checking identification band; b. checking photograph attached to the medical record; and c. if necessary, verifying resident identification with other facility personnel. The policy continues .10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.