STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555424	A. Building B. Wing	09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Dorothy & Joseph Goldberg Healthcare Center	211 Saxony Road Encinitas, CA 92024

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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F 0755 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 interview and record review, the facility failed to document and inventory medications brought in by the family, following a hospital discharge. The facility did not identify if the medication label matched the current physician's orders, resulting in a medication error for one of three residents (Resident 1), when reviewed for Pharmacy Services. This failure resulted in Resident 1 receiving a three milligram (mg) dose instead of 1.5 mg dose, as ordered by the physician. Findings:An unannounced visit was made to the facility on 9/3/25, after a complaint was filed regarding a medication error.Resident 1 was admitted to the facility on [DATE], with diagnoses which included kidney transplant, per the facility's Resident Face Sheet.Resident 1's medical record was reviewed on 9/3/25:According to the physician's order, dated 8/3/25,.Give tacrolimus (medication to prevent organ rejection), 0.5 milligrams (mg) amt: 3 capsules to = 1.5 mg oral (by mouth) every 12 hours (8 am and 8 pm) s/p Renal (kidney) Transplant: Nursing Do Not Refill: FM (family) to Supply.According to admission progress notes, dated 8/3/25 at 3:45 P.M., Licensed Nurse 6 (LN 6) documented, Patent was admitted from the hospital. There was no documentation of what medication the family provided, how many bottles, or what the dosage was.According to the social worker note, dated 8/7/25, Resident 1 was moved from the south hall to the west hall, once a private room was available in the facility. According to the nursing progress note dated 8/7/25 at 8:57 P.M., LN 6 documented, LN 4 brought to this writer's attention, patient was given 3 mg of tacrolimus instead of 1.5 mg, MD (doctor) notified with new orders for labs in the A.M., DON (director of nursing), (name) pharmacy, and patient aware of med issue.According to the nursing progress notes dated 8/8/25 at 7:38 A.M., Discussed tacrolimus incident with resident. Bottle of tacrolimus 0. 5 mg caps was found and is now on the west cart on her new hallway. Resident would like the wrong dose destroyed.On 9/3/2025, The DON and LN 6 were unavailable for interviews.An interview was conducted with the Assistant Director of Nursing (ADON), on 9/3/25 at 10:55 A.M. The ADON stated he was aware the DON was investigating a medication error involving Resident 1, that the family had brought in. The ADON stated the medication was given to staff when admitted from the hospital. The ADON was unaware if staff inspected the medication labels or inventoried the number of medications before adding to their medication cart. The ADON could not find any documented evidence or inventory of the medications the family supplied to the facility. An interview was conducted with LN 1 on 9/3/25 at 11:31 A.M., regarding Resident 1, who was no longer in the facility. LN 1 stated she was not working on 8/7/25, in the South hall, but was aware of the incident when she returned to work on 8/8/25. LN 1 stated she was very familiar with Resident 1 and had administered Resident 1's medication in the South hallway since her admission. On the morning of 8/8/25, Resident 1 approached LN 1 in the South hallway and asked to see her medication bottle and label on the South hall med cart for tacrolimus. LN 1 stated she removed the medication bottle and showed the resident the label which was listed as, one capsule equals 0.5 mg, give 3 capsules for a total of 1.5 mg. LN 1 stated Resident 1 informed her she was given 3 capsules of 1 mg dose each, equaling a total dose of three milligrams, the previous night in the [NAME] hall. LN 1 stated they must have removed the wrong bottle from the South cart when the medications were moved to the [NAME] hall. LN 1 was unable to say how many bottles of tacrolimus were originally on her cart. LN 1 stated the medication nurses should have reconciled the label on the bottles when first brought in by the family with the current physician's order.An interview was conducted with the facility's contracting pharmacist (CP 1) on 9/3/25 at 11:56 A.M. CP 1 stated Resident 1 provided her own tacrolimus to the facility and the medication was not supplied by the facility's pharmacy. CP 1 stated that sometimes residents supply their own medication, because it is not covered by their medical insurance. CP 1 stated since the pharmacy did not supply the medication, they did not provide oversite, unless the facility asks. CP 1 stated she had no documented evidence the facility asked them to review or provide oversight for the tacrolimus. CP 1 stated a one-time double dose of tacrolimus would not cause any harm or side effects. CP 1 stated the nurses should always verify the medication brought in by someone else, matching the physician's order. CP 1 stated if multiple bottles were brought in, only one bottle should have been on the medication cart and the others removed and stored for when the resident was discharged An interview was conducted with LN 4 on 9/4/25 at 3:58 P.M. LN 4 stated she was working in the west hall on the evening of 8/7/25, and Resident 1 was already settled into her new room. LN 4 stated Resident 1's medications were already on the [NAME] hall med cart, and she proceeded to give the resident her 8 P.M. dose of tacrolimus. LN 4 stated the order read tacrolimus 0.5 mg per capsule, give three capsules for a