

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555659	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER San Diego Post-Acute Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 South Orange Ave. El Cajon, CA 92020	

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 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>Based on observation, interview, and record request, the facility failed to secure medication carts when not in use by staff, for two of eight medication carts (Station 2 and Station 3), when reviewed for Pharmacy Services. This failure had the potential for residents, visitors, and staff, to obtain unauthorized medications that could cause harm. Findings: On 9/5/25, an unannounced visit was made to the facility in response to a complaint. An observation and interview was conducted in the south hall of Station 2 on 9/5/25 at 10:44 A.M.,. The medication cart was unlocked and unattended, with a resident sitting in a wheelchair next to the medication cart. Resident 1 stated she was waiting for the nurse to return, so she could get her medication. On top of the medication cart, was an opened Control Drug Record (CDR) with a sheet for Resident 2, for antibiotic administration. On the open computer, was the medication record administration for Resident 3. An observation and interview was conducted with Licensed Nurse 1 (LN 1) on 9/5/25 at 10:48 A.M. after she exited a resident room down the hall. LN 1 stated she went into a room to help a resident and forgot to lock the medication cart and close her computer. LN 1 stated with her leaving the cart unlocked, anyone could have had access to unauthorized medication. An observation was conducted of the west hall of Station 3 on 9/5/25 at 10:51 A.M. The medication cart was unlocked, and no staff were around. Other staff were observed walking past the unlocked medication cart. In the top left-hand drawer were prescription bottles, along with a clear, plastic medication cup that contained four unlabeled medications. An interview was conducted with LN 2 on 9/5/25 at 10:54 A.M., in front of the unlocked medication cart. LN 2 stated she forgot to lock the cart, before she left it and anyone could have removed medications without her knowledge. The Director of Nursing was unavailable for an interview. An interview was conducted with the Assistant Director of Nursing (ADON) on 9/5/25 at 11:06 A.M. The ADON stated she expected all medication carts to be locked and secured when not in use. The ADON stated there was the potential for medication to be removed by anyone passing by, and the medication could have caused harm. According to the facility's policy, titled Security of Medication Carts, dated 2001, .4. Medication Carts must be securely locked at all times when out of the nurses' view. According to the facility's policy, titled Medication Labeling and Storage, dated 2001 .4. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals are locked when not in use, potentially available to others.</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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