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Form Approved OMB
No. 0938-0391

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 03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Diego Post-Acute Center	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)
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure licensed nurse (LN) 2 completed medication administration for one resident (Resident 11) when two medications were left on the resident's bedside table.As a result of this deficient practice, Resident 11 was not administered his medications as ordered.Findings:A review of Resident 11's admission Record indicated the resident was admitted on [DATE] with diagnoses to include Congestive Heart Failure and Anxiety Disorder.On 3/4/26 at 11:35 A.M., an observation was conducted inside Resident 11's room. Resident 11 was observed lying in bed with eyes closed. There were two white, round pills in a medication cup on top of Resident 11's bedside table. A picture was taken of the resident's medications.On 3/4/26 at 12:13 P.M., a joint observation and interview was conducted with LN 1 inside Resident 11's room. LN 1 confirmed there were two white, round pills in the medication cup on top of Resident 11's bedside table. LN 1 stated that LN 2 was the assigned medication nurse for Resident 11 and LN 2 was on her lunch break.On 3/4/26 at 2:10 P.M., an interview and record review was conducted with LN 2. LN 2 was shown the picture taken of the two white, round pills. LN 2 reviewed Resident 11's Medication Administration Record and observed the resident's medications in her medication cart. LN 2 stated the two white, round pills were Resident 11's Lorazepam (controlled medication to treat anxiety) 0.5 milligrams (mg) and Furosemide (a medication that will remove excess fluid from the body) 40 mg scheduled to be given at 9:00 A.M. LN 2 stated she administered the medications at 9:34 A.M. LN 2 stated she left the Lorazepam and the Furosemide at Resident 11's bedside when she helped Resident 11's roommate. LN 2 stated she did not ensure Resident 11 took the ordered medications.A review of Resident 11's physician orders dated 12/10/25, indicated:Furosemide 40 mg in the morning for congestive heart failure. Lorazepam 0.5 mg in the morning for anxiety. On 3/4/26 at 2:38 P.M., an interview was conducted with LN 4. LN 4 stated complete medication administration included ensuring residents safely and fully swallowed administered medications. LN 4 stated it was important to check the resident's mouth to confirm there were no visible medications left in the resident's mouth.On 3/4/26 at 3:35 P.M., an interview was conducted with the director of staff development (DSD). The DSD stated medications should not be left at the resident's bedside. The DSD stated the licensed nurse should have ensured the resident took the medications in her presence. The DSD stated if a resident refused the medications, the medications and the medication cup should not have been left at the bedside table.On 3/4/26 at 5:02 P.M., an interview was conducted with the director of nursing (DON). The DON stated medications should not be left on a resident's bedside table. The DON stated the licensed nurse should ensure the resident swallowed the medications. The DON stated her expectations for the licensed nurse was to make sure they [residents] take it [medications].A review of the facility's undated Lesson Plan-Nursing Documentation titled Resident's Medication Distribution / Bedside Medications, indicated, .Ensure the Resident take and swallow the medications prior to living [sic] the room. NO Medication should be left by the bedside.A review of the facility's policy titled Administering Medications revised April 2019, indicated, .Medications are administered in a safe and timely manner, and as prescribed.

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