STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555659	A. Building B. Wing	03/10/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure medications were administered as ordered by the physician (MD), for one of three sampled residents (Resident 1) reviewed for medication administration.This deficient practice placed Resident 1 at risk for serious blood clots, stroke (loss of blood flow to a part of the brain), or pulmonary embolism (a blood clot that travels to the lungs).Findings:A review of Resident 1's admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses which included history of Right Hip Prosthesis (an artificial device that replaces a missing or injured body part) infection and injury of the right iliac (hip bone area) vein (transport the blood back to the heart).A record review of Resident 1's minimum data set (MDS - a federally mandated resident assessment tool) dated 3/1/26 indicated, Resident 1 had ok short term memory and was independent with daily decision making.A review of Resident 1's electronic Medication Administration Record (eMAR), the record indicated an order for .Eliquis Oral Tablet 5 MG Give 2 tablet by mouth two times a day for DVT until 02/27/2026 23:59. Resident 1's eMAR medication administration note dated 2/22/26 at 20:34 (8:34 P.M.) indicated the medication status as Pending delivery. Resident 1's eMAR medication administration note dated 2/24/26 at 21:24 (9:24 P.M.) indicated the medication status as Medication not available.A review of Resident 1's progress note titled, Nurse's Note dated 2/25/26 at 03:31 (3:31 A.M.) indicated, at .0255 that resident was on phone with 911. I went into her room to respond and met her still talking to the operator. I asked her what she needed and why she was calling 911. She told me about her not getting her eliquis [sic] fordays [sic] for DVT.Paramedics arrived at about 0305, assessed her, vs WNL but for her c/o of pains to her right lower limb.On 3/10/26 12:27 P.M., an observation and interview was conducted with Licensed Nurse (LN) 1, LN 1 stated that if a medication was not available in the facility, staff would check with the pharmacy to determine whether the medication had been delivered and place an order if it had not yet arrived. LN 1 stated staff would also search the medication room to determine whether the medication had been stocked. LN 1 reported uncertainty regarding whether the medication would be available in the emergency medication (e-kit) supply. LN 1 stated the e-kit in the medication room did not contain oral medications (injectables and intravenous medications). LN 1 stated if the prescribed medication was not available then obtaining medication from another resident with the same medication could be used until the ordered medication was delivered. LN 1 further stated Eliquis should be administered as prescribed to prevent the formation of blood clots and that failure too administer the medication as ordered may increase the risk of developing blood clots.On 3/10/26 at 12:43 P.M., a concurrent interview and record review was conducted with LN 3. LN 3 stated Eliquis (a prescription blood thinner [anticoagulant] that helps prevent blood clots from forming or getting bigger and reduces life threatening complications of deep vein thrombosis [DVT- a dangerous blood clot that forms in a deep vein, usually in the leg or thigh] that can travel to the heart or brain). LN 3 stated that if the medication was not available on the medication cart, staff would search other medication carts and contact the pharmacy to determine whether the medication had been delivered. LN 3 stated if delivery could not be confirmed or the medication was still unavailable, the physician should be notified for further direction and possible adjustment of orders. LN 3 stated (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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she was not able to locate documentation that Resident 1's physician had been notified about Resident 1's missed doses of Eliquis, due to the medication not being available on 2/22/26 and 2/27/26.On 3/10/26 at 1 P.M., a concurrent interview and record review was conducted with LN 4. LN 4 stated Resident 1 returned from the hospital with documentation which instructed the facility to continue the Eliquis order with no changes. LN 4 stated according to Resident 1's eMAR, scheduled doses of Eliquis was not administered on 2/22/26 and 2/27/26. LN 4 further stated Eliquis was prescribed to treat and prevent blood clots and must be administered as order. LN 4 stated that failure to administer Eliquis as prescribed placed Resident 1 at risk for developing serious blood clots such as DVT, stroke, or other life-threatening complications. LN 4 stated it was important to notify the physician if the medication could not be obtained within the required administration timeframe to prevent complications.A review of Resident 1's nurse practitioner note titled, PCP [primary care physician]/Internal Medicine - Progress Note, dated 2/26/26, the progress not indicated .She also complained of leg pain and was worried that she might have missed her Eliquis dose, then called 911 to take her to SGH ER @ 0305AM [sic]. She was discharged back to the facility at 0937AM [sic] per LN.A review of Resident 1's nurse practitioner note titled, PCP/Internal Medicine - Discharge Summary dated 3/1/26, the discharge summary indicated .During the recent hospital visit on 2/22, she was given Eliquis for DVT.3/10/26 1:39 PM an interview with the Director of Nursing (DON) was conducted. The DON stated Resident 1's prescribed Eliquis should have been administered as ordered because the medication was delivered by the pharmacy on 2/22/26, the day of Resident 1's admission, and this was prior to the scheduled administration time, The DON stated if the medication had arrived after the scheduled administration time, nursing staff should have notified the physician to obtain further direction, including a one-time order to administer the medication at a later time. The DON further stated on 2/24/26, nursing staff should have notified the physician when the medication was not administered. The DON stated this was critical to Resident 1's care because Resident 1 had a confirmed diagnosis of DVT and the physician should have been informed so that alternative interventions or orders could have been provided.A review of the facility's policy and procedure Administrating Medications April 2019, indicated .Medications are administered in accordance with prescriber orders, including any required time frame.